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Academy of Medicine



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IN THIS ISSUE

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Radiation Treatment Nonmalignant Diseases

Thomas H. Lipscomb

Modified Autohemic Therapy

John A. Mease, Jr.

Coccygodynia

Claude G. Mentzer

Hoover Commission Report

An Editorial

(Complete Table of Contents Page 4)



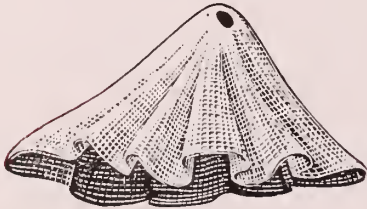
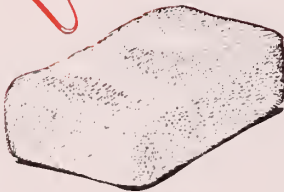
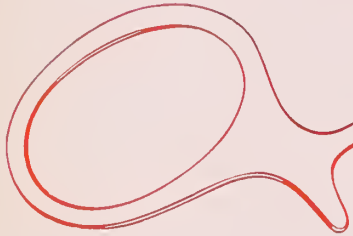
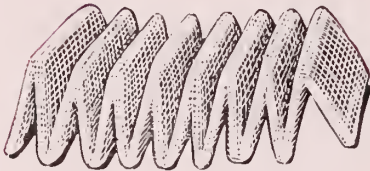
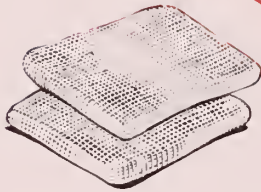
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CONTENTS

SCIENTIFIC ARTICLES

What May Be Expected of Radiation Treatment of Nonmalignant Diseases, Thomas H. Lipscomb, M.D.	19
Modified Autohemetic Therapy, John A. Mease, Jr., M.D.	22
Brief Stimulus Convulsive Therapy, Walter G. Miles, M.D.	25
Coccygodynia: Report of One Hundred and Fifty Cases, Claude G. Mentzer, M.D.	27
Problem of Surgical Amebiasis with Respect to Acute Appendicitis, Amsie H. Lisenby, M.D.	30
Preanesthetic Medication and Choice of Anesthetic Agent, Harold Carron, M.D.	32

EDITORIALS

The Hoover Commission Report; Better Government at Lower Cost	36
Wonderful Warriors, the Doctors' Wives	37
Problems of Licensure of Foreign Medical Graduates	37

COMMENTARIES

Dr. Palmer's Message	39
Maternal Mortality: United States, 1947	39
Graduate Instruction in Serodiagnosis and the Treatment of Syphilis	40

GENERAL FEATURES

Officers and Committees	34, 35
Your Blue Shield	40
State Board of Health	41
National Education Campaign	42
Members in Armed Services	42
Births and Deaths	42
State News Items	42
New Members	44
Component Society Notes	44
Joseph Rodwell Carver (Obituary)	46
Woman's Auxiliary	46
Schedule of Meetings	61
List of County Medical Societies, Presidents and Secretaries	62

This Journal is not responsible for the opinions and statements of its contributors.

FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

AN URGENT APPEAL TO YOUNG DOCTORS!



Your personal help is needed to avert a serious threat to our national security!

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

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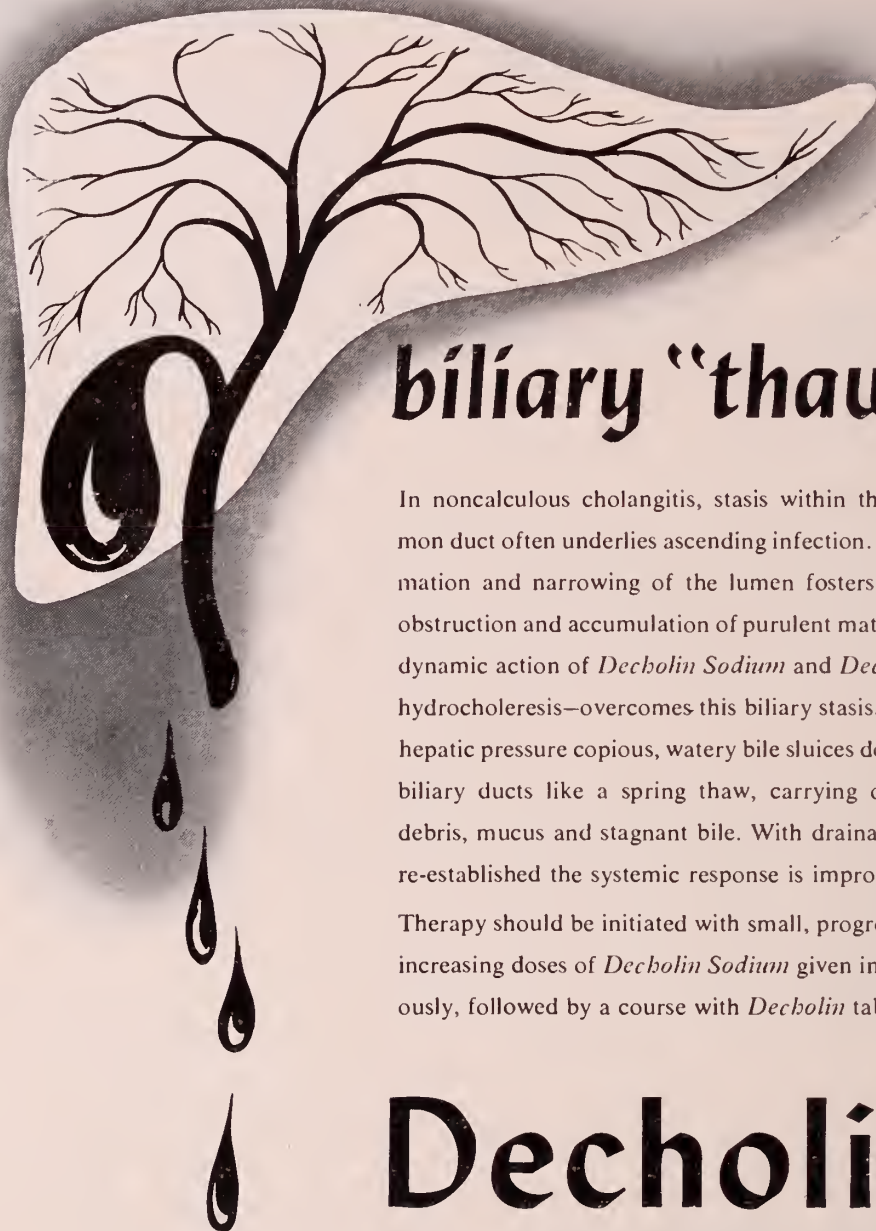
Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

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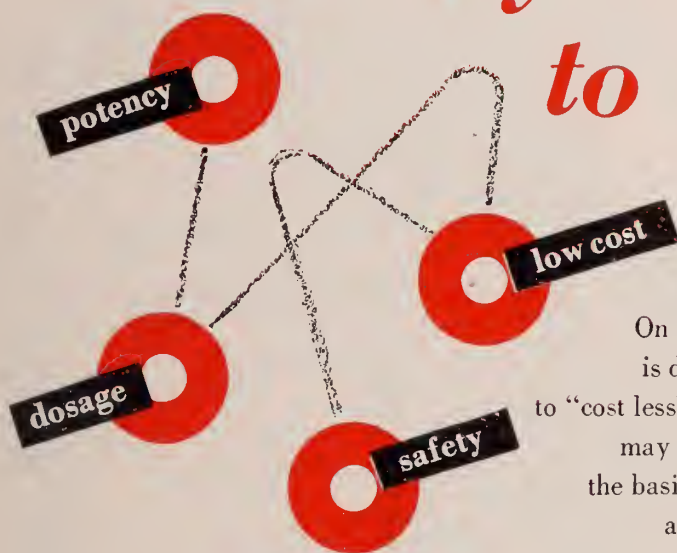
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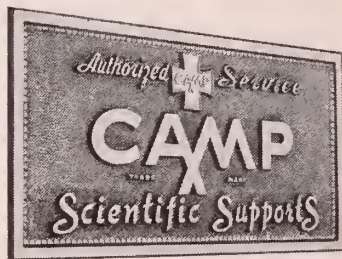



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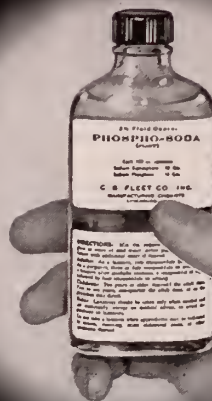
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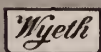
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References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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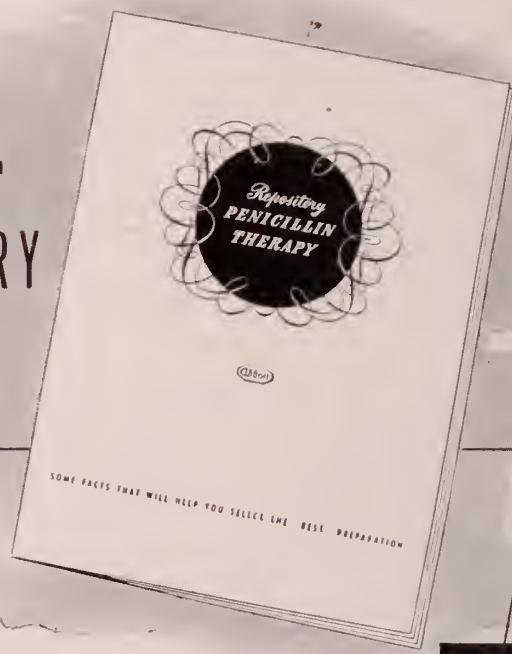


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Bibliography: (1) Hyman, H. T.: An Integrated Practice of Medicine, Philadelphia, W. B. Saunders Company, 1947, vol. 3, p. 2503.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

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Specialists in this field at the Lilly Research Laboratories are placing major stress upon the medical approach to this problem. With crystalline digitoxin and newer diuretic drugs, many victims of advanced heart failure, who formerly would have been considered beyond treatment, are now relieved of symptoms. Papaverine hydrochloride makes possible the symptomatic relief of coronary occlusion, angina pectoris, and certain types of vasospastic disease. Even though the fundamental disease condition remains, life may be prolonged and made more useful and pleasant.

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What May Be Expected of Radiation Treatment of Nonmalignant Diseases

THOMAS H. LIPSCOMB, M.D.

JACKSONVILLE

When any two people meet there are two topics of conversation almost certain to come up; first, the weather; second, health and disease.

Mark Twain said, "Everybody talks about the weather but nobody does anything about it." Recently scientists have found that by "seeding" clouds with carbon dioxide crystals they are able to cause rain to fall. Thus far one can do only a little about the weather, but everyone in this room can alter tremendously the course of disease.

A century ago a physician could intelligently follow the development of and practice in the whole field of medicine; today that is not possible. Treatment by roentgen ray and radium is only half a century old. Medical schools devote less than 1 per cent of undergraduate time to this subject, and, therefore, most medical students do not obtain an adequate understanding of radiology, and most physicians, once they are in practice, have no time for studying this intricate subject. Many physicians are not acquainted with the fundamentals of roentgen therapy and are confused and suspicious about it. They frequently confuse the effects of roentgen rays with those caused by other agents such as light, ultraviolet rays, local application of chemical irritants and so forth. It is obligatory upon the practitioners of radiation therapy to bring its merits and limitations to the attention of their colleagues. If the patient is to benefit from radiation therapy, it is necessary for the general practitioner to know what treatment by roentgen rays can and cannot do.

The principles upon which treatment is based are as follows:

1. Penetration of tissues.
2. Absorption of radiation by tissue.
3. Selective sensitivity of tissue.
4. Biologic effect of radiation.

The penetration of tissues is determined by the voltage applied to the tube, filtration by the wall of the tube and added filters, target skin

distance and density of the tissues.

The absorption of radiation by the tissues is determined by their chemical and physical characteristics and may be listed in increasing order as air-containing lung, fat, body fluids, muscle and bone.

The selective sensitivity of tissues is determined by their biologic characteristics. In increasing order of sensitivity may be listed connective, neurogenic, adenogenous, epithelial, endothelial, lymphoid and transitional tissues.

The biologic effect of radiation is as follows: Roentgen rays induce changes in the cells similar to those induced by other physical, chemical and thermal agents. The initial effect is that of depression. A somewhat larger amount will cause destruction of tissue and cell death. Tissue cells are radiosensitive in almost direct proportion to their biologic activity. Cells that are dividing rapidly or showing mitotic figures are more vulnerable than those growing slowly. Cells with increased function show earlier and greater response than those with normal function. In brief, the action of roentgen rays is inhibitory if small amounts are given, regressive for moderate amounts and destructive when larger quantities have been absorbed.

Acute Infections

From the foregoing it is obvious that in most acute infectious processes the use of small amounts of radiation is indicated. Immediately following treatment one may expect an increase in the amount of local swelling, increase in local temperature, increase in phagocytic activity of the blood generally and in the tissues locally. Conditions which respond to roentgen radiation are so many and varied that time will not permit listing all of them. One dermatologist lists eighty conditions which respond to radiation. The following conditions are cited to illustrate the general principles in treatment of acute infection:

Erysipelas has an average duration of ten to twelve days. Fifty per cent of the patients treated early with roentgen radiation will be afebrile in twelve to twenty-four hours.

Furunculosis, if treated within twenty-four hours after its initial appearance, may subside without the necessity of incision and drainage. Treatment started later may bring about a more rapid localization.

In cellulitis, immediately following radiation there may be an increase in the swelling and pain followed by sharper demarkation between the inflamed and normal tissue and reduction of pain.

Acute infections of the tonsils, external ear and middle ear frequently respond well to roentgen radiation accompanied by sulfonamide therapy. Roentgen radiation may, therefore, be a valuable adjunct in preparing a patient for tonsillectomy.

Acute parotitis, acute thrombophlebitis and acute bursitis are other conditions which frequently respond favorably to treatment by roentgen rays.

Chronic Processes

In chronic conditions the rationale of roentgen therapy is based upon:

1. Analgesic effect.
2. Inhibition of abnormal or hyperactive tissues.
3. Destructive effect.

ANALGESIC EFFECT. — Bursitis and its accompanying painful condition of calcification in and around the tendons is often a particularly painful process. Pain may be relieved in three out of four such cases with a few roentgen ray treatments. The calcified deposits are frequently absorbed in six to eight weeks.

Marie-Strumpell arthritis is a painful condition characterized by inflammatory changes in the synovial membrane and periarticular structures of the sacroiliac and spinal joints. The course, if untreated, is a progressive ascending deforming arthritis. Roentgen therapy, when started early, gives dramatic relief from symptoms, and there is some hope that it will arrest or reduce the destructive process. Treatment is usually given over the affected portion of the spine and repeated in three months.

INHIBITION OF ABNORMAL OR HYPERACTIVE TISSUES. — Patients suffering from occlusion of the eustachian tube by abnormal lymphoid tissue may be relieved by roentgen therapy directed

through the roof of the mouth by intraoral cones or by lateral ports.

DESTRUCTIVE EFFECT. — In the treatment of plantar warts roentgen therapy is given in relatively large amounts so as actually to destroy tissue and bring about an inhibition of the abnormal hyperactive tissue forming the warts. It is satisfactory in about 80 per cent of the cases.

Endocrine Dysfunctions

There is less unanimity of opinion as to the value of roentgen therapy in endocrine dysfunctions than in the conditions which have been mentioned heretofore. My personal experience has been limited to the treatment of hyperthyroidism and menopausal bleeding. In hyperthyroidism the results of roentgen therapy are probably not quite as reliable as those of surgical procedures and should be used for those patients for whom surgical treatment is inapplicable for one reason or another. Menopausal bleeding offers a field for roentgen therapy under the following conditions:

1. That clinical examination and cervical and endometrial biopsy have eliminated the likelihood of a neoplasm being present.
2. That the patient be available for study following treatment.
3. If any suspicion of a neoplasm persists, that either definitive radiation treatment for that condition or surgical procedure be carried out.

Caution

I do not advise the indiscriminate use of roentgen therapy for any and every type of complaint. I do not believe it is a substitute for good medical and surgical care.

Summary

Treatment by roentgen rays should be based upon knowledge of its fundamental underlying scientific basis.

Acute infections, especially those not responding to chemotherapy, constitute radiation emergencies. By that I mean call upon radiologic colleagues nights, Sundays or holidays.

In acute infections one or a few treatments with a small amount of energy, in chronic lesions larger amounts given at longer intervals, are indicated.

30 West Beaver Street.

Discussion

DR. AARON Z. OBERDORFER, Jacksonville: It is a pleasure and a privilege to discuss Dr. Lipscomb's paper. His clear and concise analysis of the *modus operandi* of roentgen therapy is most interesting and informative. I can speak only from my own experience in employing roentgen therapy. First, I should like to state that it has always been my policy to leave the amount and frequency of roentgen treatments entirely up to the roentgen therapist. The conditions with which I have had experience in this regard have been surgical.

In the last several years much of the drama of roentgen therapy in acute infections has been overshadowed by the antibiotics, penicillin and streptomycin. It is much like the old dependable "college widow" who now finds two attractive and available blondes on the campus. None the less, roentgen therapy still has its place together with the antibiotics, particularly in localizing infections about the face in the well known "danger areas"—and in controlling pain. Recently, I saw this combined therapy used to advantage in a case of actinomycosis of the face appearing late in pregnancy and continuing until after delivery. The primary infection was about a molar tooth with extension anterior to the ear. Massive doses of penicillin and streptomycin alone were not sufficient, even with adequate drainage, and it was roentgen therapy which turned the tide. There was team work involving surgeon, oral surgeon and roentgenologist.

I find roentgen therapy of great help in paronychia. Very early a single treatment will frequently abort the process; very late it will materially aid localization and limit the amount of surgery necessary to cure. I am not advocating substituting roentgen therapy for surgery in the average case with subungual pus which responds to the usual surgery and penicillin. In cases of fungus paronychia, roentgen therapy is even more helpful.

Furunculosis, particularly axillary, resulting usually from sensitivity to under arm deodorants is remarkably benefited by roentgen therapy, particularly with regard to pain. Frequently, when it is used with penicillin, incision and drainage are not necessary.

I do not think that roentgen therapy should be used in toxic goiter. By far the most tempestuous thyrotoxic storm I have ever seen followed roentgen therapy for Graves' disease. With present day preparation surgery can be offered in all these cases.

Plantar and palmar warts, I believe, are better treated by roentgen rays than by either excision or fulguration because this form of treatment is attended by relatively little disability or interference with normal activity.

I have enjoyed Dr. Lipscomb's paper and greatly appreciate the opportunity to discuss it.

DR. FREDERICK K. HERPEL, West Palm Beach: I am not prepared to discuss Dr. Lipscomb's paper. It was, however, timely and conservative. I am sure we are aware of the dangers of overirradiation in nonmalignant conditions. There are distinct values in stimulative therapy in many of the acute infections. The most striking results are obtained in the acute inflammatory conditions, such as boils, carbuncles, and other minor infections in which the surgeon does not wish to interfere. I have recently been impressed with the improvement in some patients suffering with arthritis, following roentgen therapy over the spine and lower back. I wish to thank Dr. Lipscomb for this opportunity to discuss his paper.

DR. FRANK L. FORT, Jacksonville: I had not intended to discuss this paper, but it seems to me worth while to direct attention to one or two other conditions commonly seen by the general practitioner which can be treated by roentgen ray radiation. The conditions in which I have found deep therapy radiation of advantage include bursitis of the shoulder and elsewhere, and especially Sudeck's atrophy or causalgia of the extremities. I do not know just what happens in these painful joints that causes radiation to give relief from pain and muscle spasm and improves the circulation. They do, however, immediately begin to improve in function, circulation and decrease of pain after roentgen therapy is begun. There is one type of ankylosed arthritis of the spine, known as Marie-Strumpell's disease, which is especially recommended for roentgen therapy. If the disease is diagnosed early and is properly treated, its progress is arrested, and to all practical purposes the patient is cured by roentgen therapy alone. No other treatment of any particular value is known for this type of arthritis of the spine. It does not benefit in the old cases, nor does it limber up the ankylosed spine. In the early cases, however, the results are brilliant.

DR. LIPSCOMB, concluding: I wish to thank all of the discussants of this paper.

I differ a little from Dr. Fort in that I think roentgen therapy has a field in arthritis other than in Marie-Strumpell disease. I have treated many retired ministers and their wives out at Penney Farms. At times some of these cases seemed to be absolutely hopeless, but willing to do what I could, I have obtained remarkable improvement from the analgesic effect of radiation. When relieved of their pain, many arthritics are found to have a considerably wider range of motion than seems possible at the first examination.

In writing this paper I have tried to bring to you only the principles involved, rather than burdening you with the details of roentgen therapy. The latter, I believe, may well be left in the hands of your radiologist.

The Scientific Department of The Journal
Reflects the Experience of You
and Your Colleagues

The Editor Invites Your Contributions
On Data of Notable Interest

Modified Autohemic Therapy

JOHN A. MEASE, JR., M.D.

DUNEDIN

The credit for first using autohemic therapy is claimed by Dr. L. D. Rogers,¹ now deceased. His definition of autohemic therapy is that it "consists in giving the patient a remedy made from a small quantity of his or her own blood without the use of drugs or bacteria," and this therapy was first used by him in 1910. He taught a number of physicians to use his technic, but so far I cannot find any report in the literature of this work except by Dr. Rogers himself, and he discussed the treatment, but gave no process for making or preparing the so-called autohemic serum. This process was explained to me by Dr. L. H. Gilleland,² now deceased, who had worked with Dr. Rogers, and I am passing it on to the members of the Association for what it is worth. To me, many of the claims made by Dr. Rogers seem preposterous. After thinking the process over for six months after the death of Dr. Gilleland, however, I decided to try it out. Mrs. Gilleland, who had worked with her husband for sixteen years, lives in Dunedin, and I asked her to help me, which she kindly consented to do. It has now been fifteen months since I began using this treatment, and I believe that there is a great deal of merit in it. I have changed the technic somewhat and am continuing to attempt to get better results. To me the term "autohemic serum" is a misnomer as the whole blood is used and not just the serum, but for lack of a better name I shall use the term serum.

Having coronary disease and arthritis myself, I took the first treatments personally and with a great deal of skepticism, deciding beforehand that they would do no good, but could not possibly do any harm. In this I was surprised, as the next day after the first treatment my arthritis had been lighted up and I ached all over. After four treatments at weekly intervals the arthritic pains were all gone, but there was stiffness in the various affected joints. After continuation of the treatment at rather irregular intervals, the stiffness also left. Following my personal experience I began to ask some of my patients with chronic conditions if they desired to take this treatment. As a result, my associates and I are now giving about forty treatments per week. The patients have all been

suffering from chronic conditions that have not responded favorably to the usual forms of treatment. No patients have received this therapy when the usually effective treatment has been indicated; so the percentage of failures is necessarily higher, I imagine, than when this treatment would be given regardless of the chronicity of the condition and when more generally accepted methods of treatment would be indicated. All patients taking the treatment were advised of its history, my inexperience in giving it, that it might do them no good, but would do them no harm, and that they would be the judges of its merits.

The cases of especial interest at this time are those of bronchial asthma and hay fever, arthritis and skin diseases except psoriasis. This one exception is a condition in which the etiology is obscure and the treatment far from satisfactory. Autohemic therapy might help psoriasis, but the time element for proof would be far beyond my own life expectancy. We are treating other classes of disease, but our numbers are too small yet to warrant any conclusions as to the effectiveness of the treatment.

There have been many variations in the preparation and administration of autohemic products, from the whole blood to the serum. The usual method, of course, is to take various amounts of blood from the patient into a syringe with or without a small amount of anticoagulant, such as sodium citrate, and immediately give it back to the patient intramuscularly. Also, in one technic, namely the persistent vomiting of pregnancy, the blood of the husband is injected into the muscle of the wife. Some of you here may have used this or some other form of autohemic therapy with various degrees of success or failure. Ross and Richeson³ in 1947 reported satisfactory results in treating acne by the use of whole blood injected immediately into the buttock and made the observation that the intensity of the treatment has an important bearing on the results obtained. Marks⁴ in 1942 used autohemic serum as a specific antigen in the successful treatment of lymphopathia venereum. The successful treatment of typhus fever has been reported by the injection of convalescent serum combined with the patient's own blood.⁵ Fresh blood and dried blood cells have been used

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successfully in the treatment of chronic ulcers of the leg.⁶ Autoserotherapy for the treatment of drug addiction has been reported with favorable results by Vivian.⁷ The difference between this treatment and the others is that the serum is obtained from a large vesicle resulting from a blistering agent. No longer than last month the successful treatment of basal cell epithelioma by the injection treatment of tissue extracts was reported.⁸ Although this is not autohemic therapy, it is closely related. There are probably many more modifications of autohemic therapy, but the ones I have mentioned are those that I have recently reviewed. There is not time to take up the chemistry and known composition of the blood, but all of you are familiar with the subject, and the details can be found in any standard book on physiologic chemistry. Suffice it to say that the body fluids are about 70 per cent of the weight of the human. These are roughly divided into the extracellular fluid consisting of blood plasma (5 per cent of body weight), interstitial fluid (15 per cent of body weight), and intracellular fluid (50 per cent of body weight). The composition of the extracellular and intracellular fluid differs although there is a rather constant exchange of the two fluids.

Procedure

When I first started this work, 10 to 16 minims of blood was drawn from any convenient and, if possible, easily punctured vein, usually on the forearm. This 1 cc. of blood was put into 15 cc. of sterile distilled water and vigorously shaken; then it was put into an incubator at 37.5 degrees centigrade and incubated for approximately twenty hours. After the incubation period the sterile water blood mixture was vigorously shaken by hand for three minutes. The mixture when first taken from the incubator contained a pellicle. The shaking broke this pellicle up and caused a large amount of foam to collect on top of the mixture. About one half of the fluid was then poured out, and the original volume was made up with added sterile distilled water. This again was shaken for three minutes, and about two thirds of the fluid was poured out, leaving the foam on top. Once more the mixture was brought up to the original volume with sterile distilled water and again shaken. Next, nearly all of the fluid was poured out, and the volume was again brought up to the original 15 cc. with sterile distilled water and shaken for three minutes. Most of this mixture was poured out except the foam, and this was

brought up to the original 15 cc. with sterile normal saline solution. This is the portion that is injected. The usual dose is from 3 to 10 cc.

I have here the bottles we use in the preparation of this serum and will briefly describe the process again. The treatment course consists of one or two weekly injections until the patient is symptom-free, and then the intervals of treatment are lengthened until one is given monthly. This schedule is maintained for a period of one year. It sometimes happens that this routine does not work, and after a three or four week interval the symptoms recur. Then weekly doses for two or three times must be given until the symptoms disappear, and thereafter the interval is again lengthened. Also, as is usual in any form of treatment, there are exceptions. Sometimes a few treatments seem to clear up the condition, and no further treatments are required. Other times there are no results with continued intensive or irregular therapy or combinations or both types of treatment.

As a general rule one of three things happens after a series of from five to ten treatments.

1. The patient immediately shows improvement or shows improvement within a maximum of ten treatments.

2. The patient has a reaction locally or systemically, which usually occurs within twenty-four hours, but some may have delayed reactions for as long as three days, and they usually persist from twelve to twenty-four hours.

3. The patient responds neither way. There is neither immediate improvement nor delayed improvement, nor is there reaction of any type. This type of patient is considered as immune or not responsive, and treatment is discontinued.

In cases of demonstrable foci of infection, as abscessed teeth, chronic cholecystitis, chronically infected tonsils and the like, the treatment is not given, or is given in conjunction with the removal of the foci. In other words, if a rheumatic patient comes in for treatment and has dental caries or suspicious apical abscesses, he is instructed to have a roentgen examination of his teeth and proper surgical procedures carried out if they are indicated. If this recommendation is not carried out, treatment is not begun, or if it has already been started, it is stopped. This policy also applies to other cases of chronic diseases with foci of infection as a possible causative agent.

As the number of patients increased, it was evident that the hand method for shaking the various dilutions was too slow and laborious; so a shaking

machine was obtained. Then further trouble was encountered. Some of the patients seemed to get better up to a certain point and just stayed there in spite of weekly treatments. After some experimentation with the number of shakes per minute, it appeared that 875 was the optimum number. By the number of strokes I mean the number of upstrokes, and these were regulated by a rheostat. The reduction in the speed of the shaking machine resulted in a preparation that caused sterile abscesses, which took about six weeks to heal. In the patients who did not have sterile abscesses, small nonpainful subcutaneous nodes were formed and persisted for about four weeks before being absorbed. This procedure did not solve all the problems; so the blood was incubated at lower temperatures, but this measure did not help. For the next step I used 2 cc. of blood in 15 cc. of sterile water, and this seemed to do the trick. At the present time we are using 2 cc. of whole blood in 15 cc. of sterile distilled water, as our first step.

You are probably wondering why the incubation and why the shaking. This is part of the procedure that was passed on to me, and I suppose it increases the sensitivity and selectivity of the antigen which is in the blood. Herein, I believe, lies the benefit of this treatment. It is certain that the pellicle which forms must be broken up, and in some instances this end seems to be more readily accomplished by hand at the first shaking than by the machine. In other words, it is an antigen which is recovered from the blood and with its sensitivity increased given back to the patient, and from this procedure the benefits are derived. It is thought to be tied up in some way with the amino acids due to the nitrogen element.

You probably would raise the question as to why go through the dilutions until a clear serum is obtained before using it because if an antigen is present, it would be so dilute that it could do no good. That is one of the first considerations that came to my mind; so I took 1 cc. of the second dilution and 2 cc. of the third dilution and injected them subcutaneously, thereby producing some of the most beautiful sloughs you could imagine. These sloughs took about eight weeks to heal and left lineal scars. For some unknown reason, as long as there is any red color in the dilution it will produce a slough.

The results of our work to March 1, 1949, the date on which I took the statistics for this report, are set forth in table 1.

Table 1.—Results of Autohemic Therapy

	Cases	Results		
		Symptom-Free	Improved	Failed
Asthma and Hay Fever	17	10	6	1
Arthritis	57*	20	25	10
Skin Conditions	12	5	3	4

*In this group 1 patient died of congestive heart failure and 1 committed suicide.

Conclusion

This series of cases is not large, and this is only a preliminary report. It has been shown that some patients respond to the autohemic treatment described and some do not. All of the patients in this series had been treated previously with the conventional recognized treatment, which had failed to benefit them. This is reported as an additional method of treatment which may be used in those cases in which there has been no response to the usual methods.

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Mease Hospital.

Discussion

DR. J. ROBERT CAMPBELL, Tampa: My interest in autohemotherapy extends back to 1935, when, as a medical student, I attempted to satisfy a strong curiosity about the therapy. The French literature, between 1910 and 1925, is rather profusely scattered with references to autohemotherapy in the treatment of such diseases as arthritis, iritis, and other infections which were considered nonspecific. Investigating the literature of autohemotherapy leads in many ways and by diverse paths into such time-honored treatments as the use of typhoid vaccine for arthritis and other conditions, and the use of nonspecific protein in the form of milk extracts, pancreatic extracts, and various tissue derivatives including enzymes, which are used with supposedly specific effect, but probably act through their nonspecific protein nature.

I employed the therapy in the early years of my practice, while associated with surgeons, and in many cases found that it brought about interesting improvement. Later, I could not help comparing the beneficial effects of histamine in various diseases and in the treatment of various symptoms with the results frequently derived in the use of autohemotherapy. Parenteral injections of any protein may bring about an inflammatory response, which may affect the general bodily functions. To some extent the response to histamine injections involves circulatory responses, which resemble inflammatory stimulation. The whole field of fever therapy, even including malarial fever

therapy, may bring about beneficial results in ways which differ from nonspecific protein therapy only in degree.

Emphasis today has been placed upon the danger of sloughing in the injection of blood derivatives intramuscularly. Actually, we are all familiar with the use of intramuscular injection of whole blood in hemorrhagic diseases of the newborn, in which treatment massive sloughing rarely occurs. The incubation procedures used by Dr. Mease must enable some change to occur which makes the blood derivative more liable to produce sloughing than does fresh whole blood. It is possible that the product described by Dr. Mease may have some different proteins than the proteins of fresh blood, but I would suspect that other changes are primarily responsible for

the sloughing rather than simple digestive fermentation of proteins.

The results that Dr. Mease has obtained are interesting, but I do not believe that the shaking and incubation procedures are necessary to achieve such results, because many investigators have found that injection of fresh whole blood can be followed by similar beneficial results in selected patients.

DR. MEASE, concluding: I think the shaking of the blood mixture and the incubation of it increase its sensitivity. I do not think this treatment is a cure-all. Also, I am going to include bone marrow in a further study. I appreciate your kind attention.

Brief Stimulus Convulsive Therapy

WALTER G. MILES, M.D.

CHATTAHOOCHEE

Electric shock therapy has progressed in the last eight years from experiment to one of the most important clinical methods of psychiatry. There has been a growing amount of information about this new form of electric convulsive treatment since its adoption six years ago. Brief stimulus therapy was developed on the basis of experimental analysis of the time factors of the excitabilities involved in electric convulsive therapy. Its aim is the decrease of postconvulsive confusion, memory disorders and electroencephalographic changes, thus permitting a decrease of the possibility of damage to the brain even when an increase of the number of convulsions may be considered as beneficial to the patient.

Almost all treatment has employed sine wave alternating currents of 60 cycles per second. This was used originally for simplicity and continued because of the excellent clinical results obtained. It has been recognized from the first, however, that this type of current was not necessarily ideal. In fact, there have always been sound theoretic reasons to believe that currents of brief duration would stimulate the desired centers with less deleterious effects.

Technic of application differs little from conventional shock therapy. The apparatus made by Offner was used in the series of cases presented.

There may be a fairly high initial skin resistance in the vertex temporal position of electrodes. Resistance is usually brought down to 500 to 700 ohms by the preliminary use of alcohol and physiologic saline, as well as by rubbing of electrode jelly into the skin (avoiding irritation of the skin). It is good practice to do at least part of the rub-

bing a few minutes before the patient lies down for the actual treatment so as not to prolong pre-convulsive anxiety. As the number of treatments increases the resistance tends to become higher, probably owing in part to improper cleansing of the treated regions.

The current for brief stimulus therapy is set for 120 pulses per second. As the current flows both above and below the zero line, the average is zero, and thus no direct current flows through the patient. This is a safety feature, as it reduces the possibility of electrolytic damage. Variations from three tenths of a second to five seconds are available. A range of from one to one and one-half seconds in most cases is sufficient; the advantage in increasing the duration one and one-half to two seconds is seldom indicated.

The strength of the current is set with the control knob. It allows a continuous variation of the output current from zero to the maximum available. Pressing the test button presets the treatment current (allowing the operator to read the exact milliamperes); it also sets the time and resets the holding peak current meter. The peak current required to obtain a convulsion with brief stimulus therapy varies from perhaps 300 milliamperes in young patients to as high as 700 or 800 milliamperes in older, deteriorated or resistant patients. It is not necessary to limit the current so nearly to the threshold value as with the older technic. It is undesirable, however, to use excessive currents as such currents will increase the severity of the initial contracture with the possible danger of fracture. It is undesirable to administer subconvulsive doses with this form of treatment because these currents appear to have a lesser effect on the consciousness than do con-

ventional electroshock currents, and an apprehension frequently exists after a petit mal.

During the past year I have treated 127 white women with this therapy, their ages ranging from 16 to 76 years. The patients in this series of cases were given an average of twelve grand mal seizures. Many of them had previously experienced conventional shock therapy and readily expressed preference for brief stimulus therapy because it did not produce so much dreaded confusion, memory disorder and headaches which make them less receptive to educational and conventional psychotherapy. Nevertheless, a great number of patients still dread this treatment. This fear, which is prominent in any form of therapy, is particularly well verbalized by the patients under brief stimulus therapy because of the perseveration of their intellectual aptitudes. This fear may, however, be overcome in the great majority of patients, not only by the technical adjustment or different factors involved in the treatment, but also by a firm and patient management of each individual case by the physician and nursing staff. No accidents were encountered, and no analeptics were used.

In summary it can be stated that a favorable response to the first three treatments generally indicates a good outcome with quick remission. Results were best in simple endogenous or menopausal depression and were poorest in cases with prominent schizophrenic features. In recurrent depression, treatment not only was valuable at the end of the episode but could also effectively abort an incipient depression. Wilcox,¹ in a careful analysis of over 2,000 cases, concluded that 40 per cent of even the most chronic cases can be helped by protracted and persistent treatment.

Unidirectional, pulsating current produces less confusion, less memory difficulty, and fewer electroencephalographic changes than alternating current, but is also associated with much more apprehension. It is frequently used in combination with pentothal sodium. The Glissando effect, involving a progressive increment of current, diminishes the force of the initial jolt and the risk of vertebral fracture. A somewhat similar effect can be secured by introducing treatment with a small subconvulsive dose, followed immediately by a grand mal. Opinion is still divided on the routine use of curate. Wilbur and Fortes² were of the opinion that it is helpful in the treatment of old patients.

A growing variety of electroshock treatment technics is being employed. This should lead to

greater individualization of treatment, but the indications for each variation are still too obscure. One author stated that treatment can often be limited to four to six treatments in cases in which the patient responds well. Savitsky and Karliner³ reported that 34 per cent of their cases required five or less treatments. Even cases that require more intensive treatment can now be handled in a week or two. Wilcox¹ begins in such cases with daily treatment (using unidirectional current), diminishing the frequency of treatments as patients begin to improve.

Milligan⁴ described a method of intensive treatment, involving up to four shocks a day, in which prolonged states of confusion are deliberately induced. He reported excellent results in anxiety states, hysteria and obsessional states, especially in chronic cases resistant to psychotherapeutic influence. He did not find memory difficulties especially pronounced thereafter. Thorpe⁵ also recommended intensive electroshock treatment in acute manic excitement. From three to six treatments are given in the first day with gradual diminution of frequency of treatment as the excitement is controlled. Twelve cases were treated successfully in this way without danger or undesirable sequelae.

Tyler and Lowenbach⁶ found that they can often shorten the entire period of treatment to four or five days by administering four treatments on the first day and less on succeeding days. A state of confusion is thus maintained throughout the course of treatment; but according to these authors there is no increased tendency to memory difficulty, intellectual defect or brain damage after treatment is concluded. They especially recommended the procedure for schizophrenia or agitated depressions, or in other cases when time is an important factor.

Summary

The value and technic of brief stimulus convulsive therapy are discussed.

A series of 127 cases in which this treatment was used is reported.

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Florida State Hospital.

Coccygodynia: Report of One Hundred and Fifty Cases

CLAUDE G. MENTZER, M.D.

MIAMI

It is the purpose of this discussion to direct attention to an ailment too frequently overlooked by the proctologist, namely, coccygodynia. A review of my records for the last nine years shows this diagnosis to have been made in 150 cases.

Simpson^{1a} first described and named this condition "coccygodynia" in 1859. He ascribed the pain to the contraction of muscles attached to the coccyx, which had been injured previously, or was the site of inflammation. Though not a recently discovered entity, it has been recognized by few physicians, and the unfortunate patient has been deprived of the quick relief now available. Thiele,^{1a} in 1934, first observed these muscles to be in tonic spasm and worked out a simple and effective treatment, massage. So, a diagnosis is first necessary before treatment for relief can be given.

A brief review of the anatomy of this area will help in more clearly interpreting the evidences of coccygodynia. The coccyx is composed of four or five segments which usually fuse, but may establish joint movements. In either case, it seems to have little bearing on the coccygodynia complex unless caused by the trauma of fracture or dislocation. The coccyx lies midway between the ischia, being somewhat protected by them, more so in the male. It is not only the caudal end of the spinal column but is also the point of attachment for four muscles—the lower portion of the gluteus maximus, the coccygeus, the posterior portion of the levator and the superficial portion of the external sphincter ani. An intricate network of spinal nerves supplies these structures and with the autonomic nerves also innervates the anal canal, rectum and pelvic urogenital organs. Because of this intercommunicating nerve structure, the coccyx also may be the site of pain far removed from the causative lesion by a referred mechanism. Kleckner² made a simple classification which coincides with the anatomic concept: (1) coccygodynia, real or true, and (2) pseudococcygodynia, or referred type.

A diagnosis is often suggested by the way a patient squirms about after sitting awhile, and the

evident distress when getting up from the sitting position. The pain rapidly disappears after walking a little. Many find that lying on the back causes pain in this area and are relieved by turning over on the abdomen. Some relief is often obtained after defecation.

In looking for coccygodynia, as with any diagnosis, two moss-grown adages should be observed, "one finds what one looks for" and "think of all the possibilities." Too often a urologist or gynecologist overlooks a rectal carcinoma within reach of the index finger. Likewise, the proctologist is often unable to tell whether a patient even has a prostate after a rectal digital examination, much less cancer of the prostate or cervix, or coccygodynia.

The digital or rectal examination clinches the diagnosis of coccygodynia suggested by the history. The coccyx is palpated with the index finger inserted its full length into the rectum and then manipulated bimanually. In coccygodynia, extension of the coccyx causes pain. The ischial spine is then located on one side, and with deep pressure, the finger is moved toward the coccyx, thereby pressing on the levator and coccygeus muscles on that side. This pressure is repeated on the opposite side, and the difference in tone is noted. The patient is asked which side is more tender to pressure, and in almost every case there is unilateral spasm when coccygodynia is present, and this manipulation almost invariably reduplicates the pain.

In differential diagnosis, a deep-lying ischio-rectal or supralelevator abscess must be ruled out. In the latter case, the pain is different, being continuous even when the patient is walking, and urologic symptoms are more often present. Also, there is fever. Tenderness to deep pressure on the skin overlying the abscess is present, and digital examination reveals a boggy, tender encroachment into the rectal lumen rather than the tense border of a spastic muscle. And, fissure and cryptitis must also be kept in mind, but here, too, the pain is different and usually increases rather than lessens after a bowel movement; it is characterized by burning and cutting rather than the cramping in coccygodynia.

Read before the Florida Proctologic Society, First Annual Meeting, St. Augustine, April 11, 1948.

With this brief survey of applied anatomy, diagnosis, and classification into true and referred types of coccygodynia, it will be of interest to analyze the information obtained from the case records of 150 patients suffering with this ailment.

The sex incidence is predominantly female, with a ratio of 133 to 17. Of the 133 women, 63 had had pregnancies, while 70 had not. Only 1 gave a history of injury to the coccyx during delivery.

The youngest patient was 23 and the oldest 74. The largest number of patients, 58, were in the fourth or menopausal decade (table 1).

Table 1.—Age Incidence

Age	Patients
23 to 30	4
30 to 40	34
40 to 50	58
50 to 60	46
60 to 70	7
74	1

There was a history of injury to the coccyx in only 8 of these cases. A roentgen study of this area was made in 9 cases. In 4, the results were negative; in 1, fracture was present, and in 4, arthritis of the sacrococcygeal joint.

There was tonic spasm of the levator and coccygeus muscles in every case. It was unilateral in 112 cases and bilateral in 17; the side was not stated in 21.

This series of cases is divided into three groups: Group I consists of cases of coccygodynia without proctologic disease, numbering 64. In 27 of these cases there had been no anorectal pathologic condition, and in 37 rectal surgery had been performed one to twelve years before, but not at the time of examination. Group II comprises those cases in which coccygodynia and proctologic disease coexisted. They numbered 53. Group III consists of 33 cases in which coccygodynia developed two weeks to one year following anal surgery (table 2).

Table 2.—Coccygodynia

Group I	Without proctologic disease	64
Group II	With proctologic disease	53
Group III	Following proctologic surgery (2 weeks to 1 year)	33

Treatment

As soon as the diagnosis of coccygodynia was made in this series, massage of the involved muscles was started. In the cases classified in groups I and III the treatment was similar. In those in group II surgery or medical treatment was advised, plus massage. In this group there were 53 patients; 27 were operated upon, 11 were treat-

ed medically, and 15 received no treatment for anal disease.

The method of massage is as follows: The index finger is inserted full length into the rectum and is then swept from the ischiac spine to the coccyx on the affected side, pressure being exerted on the levator and coccygeus muscles. The first massage is usually light. If the diagnosis is correct, the patient observes noticeable relief for twenty-four to forty-eight hours. The second massage should follow twenty-four to forty-eight hours after the first. It can usually be heavier and longer as the treatments progress. When a patient is asked to return in four days and has had relief for only two days, the next visit is set at two days, and then the interval between treatments is gradually lengthened. In the more painful cases in groups I and II, an injection of an oil-soluble anesthetic about the coccyx and into the involved muscles was advised and was carried out in 45 cases under caudal or local anesthesia, in addition to the massage. Massage alone was done in 105 cases. The number of treatments varied from 1 to 21, with an average of 5.7 per patient.

Results of Treatment

In 75 of the cases in this series the patients were contacted one week ago and asked about the status of the coccygodynia. From this information and from an approximate evaluation of results from the records of those not contacted, the summary in table 3 gives a rather close estimate of the results of this therapy.

Table 3.—Results of Treatment

Patients	Cured	Improved	Unimproved
Group I 64	44 or 69%	16 or 25%	4 or 6% (without)
Group II 53	30 or 57%	20 or 37%	3 or 6% (with)
Group III 33	27 or 82%	5 or 15%	1 or 3% (after surgery)

These figures are similar to those for a series of 142 cases reported recently by Thiele.^{1b} His results were 66 per cent cured, 28 per cent improved and 5 per cent unimproved. The 5 per cent group were all medical cases.

In my series, 4 patients had had coccygectomy without relief. Massage cured all 4. Coccygectomy cured 2 patients when massage had failed.

Discussion

Applying Kleckner's classification² of true and referred types to this series of 150 cases shows

that true coccygodynia was present in only 12, while in the others pseudococcygodynia, or the referred type, was present.

This latter term implies that the coccyx is not itself injured or diseased, and that the causative factor is some other stimulus which is responsible for the reflex spasm of the levator muscles, thereby simulating a true coccygodynia. Thiele¹ was of the opinion that focal infection is most frequently found in the anal crypts and the pelvic-genitourinary organs. This theory may apply to groups I and II, those without proctologic disease and those with it, but it does not entirely explain group III.

Gorsch³ may have the answer for the cause of the pain in this third group. He has directed attention to the composition of the conjoined longitudinal muscle. This is composed of fibroelastic extensions of the levator (striate muscle) and the smooth muscle from the longitudinal coat of the rectum. These conjoined muscles extend downward from the levator level and send out multiple septums between and through the various parts of the external sphincter; they are attached to the anal skin at the level which is called the white line of Hilton. The two kinds of nerves, spinal and autonomic, supplying these two types of muscle are therefore in the right place to be stimulated by foci of infection or any other painful condition such as firm scars resulting from recent anal surgery and the infection coincident to wound healing in the anal canal. This last factor may explain the early occurrence of coccygodynia after anal surgery. Massage hastens relief. Perhaps if the coccygodynia symptom were not called to the attention of the patient by the proctologist, it probably would be accepted as one of the usual sequelae of anal surgery. Relief would and has come in many unsuspected cases by the softening of these scars and the regeneration of the nerve end caught in them. In all this theorizing the unilateral spasm has not been explained.

In group I, without proctologic disease, focal infection in the pelvic-genitourinary tract has not been ruled out as carefully as it should have been.

Another factor which predisposes patients to this ailment is the lowered nerve threshold occurring in women and in the age group coincidental with the menopause. There were 57 women between the ages of 40 and 50 in this series.

The following brief reports of cases offer a sample variety of causative factors.

Report of Cases

Case 1.—A white woman, aged 74, had symptoms of severe coccygodynia, previously diagnosed as sacrococcygeal arthritis and confirmed by roentgen examination. Digital rectal examination revealed tenderness of the left levator and coccygeus muscles. She had complete relief after six massages and the injection of 10 cc. of anucaine.

Case 2.—A white man, aged 35, had cryptitis and coccygodynia with unilateral spasm of the levator and coccygeus muscles. Repeated massages by both Dr. Thiele and myself gave temporary relief. Cure was finally effected by a cryptectomy done by Dr. Thiele.

Cases 3 and 4.—Two white women, aged 28 and 29, gave a history of a fall and injury to the coccyx. Both had been subjected to coccygectomy before I saw them; so I do not know the roentgen findings. They continued to have coccygodynia and were completely cured after massage. One was massaged five times and the other twelve times.

Case 5.—A white woman, aged 35, could neither sit, nor get up, nor lie comfortably after receiving a blow in the region of the coccyx and she suffered severe pain. Thinking to take her mind off her trouble, she decided to go on with her horseback riding. While she was mounting, the horse started suddenly and landed her in the saddle forcibly. She had sudden pain and then was completely relieved. Reduction of the dislocation was effected in this manner.

Case 6.—A white woman, aged 55, had had a complicated fistulectomy two years previously and a fecal impaction in the early postoperative period. When she consulted me, coccygodynia with right-sided muscle spasm was present. She was massaged, and during the second treatment a hard fecal ball, 1½ inches in diameter, was felt and broken up. After expelling this with an enema, she was completely relieved.

Case 7.—A white woman, aged 49, had associated anal crypt, fissure and coccygodynia with spasm of the right levator. She also had an early hydronephrosis due to pelvic obstruction and ptosis of the right kidney. Following anal surgery and massage, coccygodynia was relieved 75 per cent. Symptoms return, however, when she has what she calls a "G.U. flare-up."

Conclusion

Coccygodynia is more prevalent than suspected and if looked for, will be diagnosed with greater frequency.

There are two types of coccygodynia, the true and referred. Cases of the latter outnumber those of the former 12 to 1.

It is thought that a focal infection is the etiologic factor in referred coccygodynia, causing tonic spasm through a nerve reflex.

The diagnosis is easily made.

The treatment is simple and can be carried out in the home, office or hospital. Elimination of infection is done by surgery or medical treatment, as indicated. The results of treatment are gratifying.

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Problem of Surgical Amebiasis with Respect to Acute Appendicitis

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Every physician in the United States should be alert to the fact that he will inevitably come in contact with amebiasis, caused by *Entamoeba histolytica*, and should prepare himself accordingly. Hummel¹ and Barr,² as well as Craig and Faust,^{3a} demonstrated conclusively that this parasitic invasion occurs in at least 10 per cent of the general population. Faust⁴ estimated the incidence at 20 per cent.

Why such a high percentage exists is difficult to say, other than the fact that this disease is easily transmitted. Since the war the incidence is considered greater because of soldiers who were stationed in the South Pacific acting as carriers. Cysts acquired through unboiled water may lie dormant in the pouches of the large intestine for years, some leaving through the feces from time to time. This circumstance makes the country latrines specifically dangerous in so far as these released cysts are still accessible to flies, which may contaminate foods, especially green vegetables.

Also, it is empirically true that amebiasis can express itself in many bizarre symptoms so as to confuse an unalert physician. Craig and Faust^{3b} emphasized: "Clinically the various phases of infection with this ameba may be mistaken for other disease conditions, most frequently for bacillary dysentery; mucous colitis and other forms of colitis; carcinoma of the rectum; chronic enteritis; schistosomal and balantidial dysentery; chronic appendicitis; food allergy; gallbladder disease; peptic ulcer, and chronic gastritis."

Ochsner⁵ stated in a report of a study made at the Charity Hospital in New Orleans that 10 per cent of the patients who had appendicitis also had amebic involvement.

Two years ago my associates and I gave little thought to amebiasis as a local possibility, for we generally considered it to be a tropical manifestation. It happened, however, that a staff member was stricken with severe pains in the epigastrium. He had no diarrhea. Roentgen and laboratory examination showed the presence of amebiasis with granuloma of the cecum. Since then we have been alert for such parasitic invasion and, in consequence, have found 24 cases that presented a

history of one or several of the following symptoms: indigestion, gas, a feeling of fulness, recurring pain, nausea, or general abdominal discomfort. Few patients gave a history of diarrhea. After talking with these patients, we would come to the conclusion that most of them were of a nervous disposition, and they would admit that they were "a little nervous." Then, with nothing definite to put our finger on, we would make a diagnosis of nervous indigestion. We treated them for this with some degree of success. For the last two years, however, we have been more cautious about treating or mistreating patients with vague abdominal symptoms for nervous indigestion. Many of these patients will be found to be suffering with amebiasis if stool examinations are made.

In several cases in which gastric or duodenal ulcers were suspected, a roentgen study of the gastrointestinal tract was made. No evidence of ulcer was found. A filling defect was, however, noted in the cecum or ascending colon. In 6 such cases, amebiasis was suspected, and a stool check was made. Amebae were found in 5 of these 6 cases. We had one other case in which the patient, with a history suggesting amebiasis, had been checked by three other doctors in three other cities with negative results. Thinking that he was perhaps suffering from chronic ulceration of the stomach or duodenum, we ordered a roentgen examination of the gastrointestinal tract. No such evidence was found, but a filling defect in the ascending colon was noted. Two stool checks showed no amebae. Nevertheless, the evidence was so strong in favor of amebiasis that we gave him the regular treatment for amebiasis anyway, after which he stated that he felt free of abdominal discomfort for the first time in three or four years. The filling defect shown in the roentgenogram was caused by the granulomatous tissue in the mucosa of the intestine, giving a peculiarly mottled appearance. This should and will disappear after treatment.

Wilbur and Camp⁶ reported similar findings. They stated: "The earliest lesions are those involving the mucosa, and in our experience the cecal walls lose their sharp, smooth character and

are replaced by finely granularlike or irregular contour of the mucosa which may be associated with varying degrees of cecal spasm."

Discovering the earlier phases of amebiasis disguised as mild abdominal symptoms is a fairly routine occurrence, providing the roentgen examination and stool checks are made carefully and, if giving negative results, repeated. Also, an indication of amebiasis is hinted at when the blood test shows a leukocytosis of from 10,000 to 30,000 and the polymorphonuclears are less than 75 per cent of the total. Wilbur and Camp⁴ concluded that if the polymorphonuclears exceed 80 per cent, "the condition probably isn't amebiasis."

The greatest problem lies in the determination of amebiasis in the more advanced stages. Like Ochsner,⁵ we have found amebae present when the symptoms seemed to indicate acute appendicitis. This poses a vital problem, because there is not enough time to give a saline purgative, followed by roentgen and stool examinations, when there might be a ruptured appendix in the making. This is contraindicated anyway in the presence of suspected appendicitis. On the other hand, the physician must not forget that the mortality in surgical cases in the presence of amebiasis in the Chicago epidemic of 1933 was 40 per cent. The enigma confronting him in the form of the various amebic surgical complications may be effectively demonstrated in the following cases:

Report of Cases

Case 1.—A white man, aged 28, consulted me complaining of acute pain in the lower right quadrant of the abdomen of eighteen hours' duration. Another doctor had made a diagnosis of appendicitis. This patient, incidentally had visited me three months previously, and I had diagnosed his abdominal irritation as indigestion with consequent gas pains.

Examination of the abdomen showed extreme tenderness with a mass present in the area of the appendix. It was thought to be a walled-off appendiceal abscess. The temperature was normal. A blood count showed 15,000 white blood corpuscles with 85 per cent polymorphonuclears. Urinalysis gave negative results. There was nothing of consequence in the patient's history. The question was whether to operate or leave the mass alone as long as nature seemed to be taking care of it and general peritonitis had not set in.

After consultation, since it might be a walled-off acutely inflamed appendix and in such case a rupture might be prevented, we decided to operate. Upon opening the abdomen through a McBurney incision, we found a large mass measuring about 5 cm. by 6 cm. in the lateral cecal wall which was gangrenous and rapidly breaking down. Under these circumstances we did the only thing we could do. We extended the incision and exteriorized the cecum, the ascending colon, a small part of the transverse colon, and a small part of the terminal ileum. After suturing the serosa of the two pieces of intestine together, which we planned to leave for anastomosis later by use of the spur crusher, we closed the wound about the intestines. This operation required three stages, because we had not expected to find such a condition and could only apply temporary measures. Had we

expected such a tumor and believed it necessary to operate, we would have given the patient sulfasuxidine for a period of four or five days and then performed a one stage closed anastomosis to eliminate the gangrenous condition of the bowel.

We removed the excess bowel in forty-eight hours and sent the tumorous mass to a pathologist for diagnosis. Though it did not appear to be carcinomatous, we were not certain. As Hodes and Mammoser⁷ reported, carcinoma is often mistaken for ameboma (amebic granuloma). We still had not suspected amebiasis. The pathologist reported that grossly the condition did not look like carcinoma, but gangrenous changes had prevented him from making a microscopic diagnosis.

The spur crusher was used as soon as we had removed the excess bowel, and when the spur was sloughed out, we closed it with Babcock stainless steel wire. Not until nine days later, after we had received a similar case (case 2), did we suspect amebiasis. We then examined the stools and found *E. histolytica*. The patient was soon dismissed, but had to return later for more medical treatment because not all the amebae had been destroyed by the first treatment. We use emetine hydrochloride and diodoquin in the treatment of amebiasis.

Case 2.—A white man, aged 34, came to us with a severe pain in the lower right quadrant of the abdomen which had developed the day before. He was sent by a colleague who had been treating him for stomach trouble. At that time he showed a leukocytosis of 11,500 with 72 per cent polymorphonuclears. Urinalysis gave negative results. He gave a history of "stomach trouble" and of having had treatment for "nervous indigestion" during the last three years. He had had occasional diarrhea.

Examination elicited acute pain over McBurney's point, and with the laboratory findings acute appendicitis was our diagnosis. We made an incision over McBurney's point and found a tumor mass about 4 cm. by 5 cm. in size in the lateral cecal wall. The lesion was in about the same place as it was in case 1. The tumor was gangrenous and was beginning to break down.

The same operation described in case 1 was performed, and the specimen sent to a different pathologist. He reported no evidence of malignant disease and asked what we suspected. I stated that we suspected amebiasis first and carcinoma second. After staining other sections for amebae, he reported *E. histolytica* in the intestinal wall. (At this time we suspected amebiasis in case 1 and checked the stools.) Treatment was begun immediately and later a three stage resection was successfully concluded by the same method as in case 1. An infection of the wound developed from contamination at the time the intestine was exteriorized. After this was cleared up, the wound was closed as before with Babcock stainless steel wire and it healed promptly.

Discussion

These cases clearly indicate how a physician may be confronted by one of *E. histolytica*'s many disguises and not recognize the genuine etiologic factor. Confusion may be added by the apparent necessity to make a quick decision. Is the appendix about to rupture? Surgery is possible, but as Hawe⁸ put it: "With few exceptions, abdominal or rectal operations are strongly contraindicated in patients suffering from intestinal amebiasis. . . they are often followed by serious complications peculiar to this disease." But, what to do, once you have operated for acute appendicitis and find a mass which is already gangrenous? The mass must be removed, and we feel that the three stage operation offers less morbidity and mortality. In considering the differential diag-

nosis between acute appendicitis and surgical amebiasis, we are free to state that this is impossible in the light of the physical examination, the laboratory reports and the time element that is necessary for urgent treatment.

Summary

Amebiasis occurs frequently enough in the United States for every physician to encounter it sooner or later. The return of thousands of veterans exposed to its invasion signifies the greater number of cases to be anticipated in the future.

The diagnosis often is missed because of failure to think of this disease and the unwillingness of many physicians to do stool examinations. There is a high probability that most of the cases in the earlier stages can be diagnosed by the employment of roentgen examination and stool-testing procedure. Examination of the blood may also indicate an amebic condition.

Amebiasis frequently expresses itself in many bizarre symptoms, and the advanced stages can be

dangerously involved. Acute appendicitis is simulated when the disease is in an advanced stage. The condition may be either amebiasis or an appendix about to rupture. Operation is possible, but a high percentage of mortality in surgical cases in the presence of amebiasis has been effectively demonstrated.

Two illustrative cases are reported.

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Box 961.

Preanesthetic Medication and Choice of Anesthetic Agent

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The administration of sedative and hypnotic drugs prior to the induction of anesthesia has long been a part of routine orders prescribed by the operating surgeon, but in fact these drugs are actually a part of the whole anesthetic procedure. Their influence is exerted on the anesthetic and not on the surgery. It is imperative, therefore, that the proper drugs be prescribed for the type of anesthesia to be employed.

Proper preanesthetic medication results in a cooperative patient with anxiety relieved, metabolic activity reduced, pain threshold heightened, and amnesia for the operative procedure and anesthetic induction. Individualized medication further eliminates respiratory irregularities during the induction of anesthesia and vagal and carotid sinus reflexes. These desirable effects must, however, be obtained without depression of circulation, respiration, or compensatory mechanisms.

The three main classifications of drugs used as preanesthetic medication are (1) the narcotics (morphine and its substitutes), (2) the bella-

donna group (atropine and scopolamine), and (3) the barbiturates. Morphine has proved the most efficient of the narcotics for premedication, for its effects are more consistent than those of demerol. It produces less cardiac and respiratory slowing than dilaudid, and may be used in smaller doses than pantopon. Improper timing of the administration of preanesthetic narcotics is most frequently responsible for excitement during induction, undue respiratory depression during the anesthesia and prolonged postanesthetic depression. When given subcutaneously, the maximum optimal effect of morphine is obtained in sixty to ninety minutes, intramuscularly in thirty to sixty minutes, and intravenously in approximately fifteen minutes. Morphine administered prior to emergency surgery should always be given intravenously (slowly) in order that adequate sedation may be obtained prior to the induction of anesthesia.

Among the functions of the belladonna group of drugs are the depression of mucous secretions, the depression of vagal reflexes, and respiratory stimulation to overcome the depressant effects of

morphine. Scopolamine has the advantages over atropine in equivalent doses of producing amnesia, psychic sedation, greater peripheral effects on secretions and better respiratory stimulation. These drugs are most efficacious when used in the ratio of 1:25 with morphine.

Barbiturates as premedication permit the use of impotent anesthetic agents, increase the hypnotic effect, and protect against the convulsive manifestations of cocaine and procaine poisoning.

The dosage of preanesthetic drugs is largely dependent upon the metabolic activity of the individual patient. Metabolism varies with age, reaching its maximum at puberty and declining gradually until old age. Table 1 serves as a rough guide to the dosage of preanesthetic drugs to be used.

Table 1

Age	Morphine	Atropine	Scopolamine	Nembutal
0-1	0	0	0	0
1-2½	0	1/300 gr.	0	0
2½-5	1/12 gr.	1/200 gr.	0	3/4 gr.
5-12	1/8 gr.	0	1/200 gr.	1 1/2 gr.
12-60	1/6 gr.	0	1/150 gr.	3 gr.
60-75	1/8 gr.	0	1/200 gr.	1 1/2 gr.
75-	1/12 gr.	1/200 gr.	0	0

Atropine is substituted for scopolamine below the age of 5 and over the age of 75 since in these age groups excitement will often result from the use of scopolamine.

While the accompanying table will serve as an index for premedication, dosage, however, must be individualized. Cachexia, debilitation and chronic diseases require a decrease in dosage; on the other hand, thyrotoxicosis, drug addiction and acute pain require increases in dosage for the patient's comfort.

The factors which must be taken into account in the choice of anesthetic agent and technic include the safety and comfort of the patient, the convenience to the surgeon, and the skill and training of the anesthetist. All anesthetic agents should be selected upon the basis of their pharmacologic properties. Ether, without question, is the safest anesthetic in the hands of unskilled or semiskilled technicians; yet of all the anesthetic agents, it probably produces the greatest derangement of normal physiology. It depresses the temperature-regulating mechanism, increases intracranial pressure, increases glycogenolysis and elevates the blood sugar 100 to 200

per cent, irritates the larynx, depresses renal function and decreases the motility of the stomach and intestines. Among its advantages may be listed the wide margin of safety between anesthetic and toxic doses, its lack of effect on blood pressure and heart muscle, and the production of splenic contraction, thereby increasing circulating blood volume.

Cyclopropane has the advantages of rapid induction and recovery, lack of effect upon the gastrointestinal tract, moderate relaxation, and low concentrations required for anesthesia, thereby allowing the use of higher oxygen concentrations. Its disadvantages include a low margin of safety between anesthetic and toxic doses, the production of cardiac arrhythmias, elevation of blood pressure, respiratory depression, and a high incidence of postcyclopropane hypotension.

Nitrous oxide and ethylene may be considered together. They both have the advantages of little if any alteration in blood chemistry, no effect on peripheral circulation, pleasant induction, rapid recovery, and the fact that no respiratory failure is possible in the presence of sufficient oxygenation. Disadvantages of these agents are primarily the lack of relaxation produced and the fact that heavier premedication is required for induction and maintenance of anesthesia.

Pentothal sodium, the newest of the anesthetic agents in common use, is perhaps now the most used and misused of all the anesthetics. It is true that induction and recovery are pleasant for the patient, that there is minimal postanesthetic nausea and emesis, that it is nonexplosive, and that it requires little in the way of apparatus. Nevertheless, this drug has minimal analgesic properties and does not produce relaxation; there is a very small margin of safety between anesthetic and toxic doses; laryngeal reflexes are augmented frequently to the point of laryngeal spasm; and the circulation is depressed. Some other agent should be used with pentothal sodium to produce analgesia, thereby reducing the amount of barbiturate required to maintain narcosis and allowing a more even anesthesia with more rapid recovery. Anesthesia produced by intravenous barbiturates alone is little more than profound barbiturate poisoning.

Spinal anesthesia should be considered a "general" anesthetic since there is a profound derangement of physiology produced by the intraspinal injection of local anesthetic drugs. Spinal

anesthesia once induced cannot be reversed, and changes in physiology require compensation by the further injection of drugs. Among its disadvantages are fall in blood pressure resulting in cerebral anoxia, occasional respiratory paralysis, neurologic sequelae, and the fact that the incidence of respiratory complications may be higher than when an inhalation agent is used. The advantages of spinal anesthesia are primarily those of absolute muscular relaxation with contraction of the intestines.

Regional, infiltration and block anesthesia have limited application since anesthesia is frequently incomplete. The procedure is time-consuming, and the patient must be either extremely cooperative or overpremedicated to the point of respiratory and circulatory depression.

Basal narcosis with such drugs as avertin or rectal ether is required in specialized cases. This technic eliminates the apprehension of the patient, permits the use of impotent anesthetic agents, decreases metabolic activity, and is of particular usefulness in the treatment of convulsions, tetanus and status asthmaticus. Once administered, however, they are relatively uncontrollable, and there exists a high incidence of postoperative pulmonary complications due to the prolonged depression and anesthesia produced.

Summary

In summary, the choice of an anesthetic agent for any surgical procedure should be that which satisfies the surgical requirements while producing the least derangement of physiologic processes. In general, abdominal and rectal procedures require ether, cyclopropane or spinal anesthesia; surgery of the head and neck, skin and extremities, and external genitalia can be safely and satisfactorily performed under the less potent agents. In the presence of shock, cyclopropane has proved to be the anesthetic of choice since it allows the highest concentration of oxygen and maintains the blood pressure. Spinal anesthesia is contraindicated in the presence of shock, severe anemias, intestinal obstruction of the dynamic type, extremes of hypertension and hypotension, and cardiac disease, or when neurologic lesions of any type are present. It should be remembered that the anesthetic must meet the surgical requirements and not increase them, and that a minor surgical procedure does not require a major anesthetic procedure.

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The Hoover Commission Report Better Government at Lower Cost

At this writing former President Hoover, Chairman, and members of the Commission on Organization of the Executive Branch of the Government have officially presented to President Truman a specially bound set of its reports containing 318 recommendations. The nineteenth and final summing up report contains the warning that past reorganization plans were of "little value" because they were carried out piecemeal or not at all.

This 12 man Commission was set up in 1947 by the Congress to advise about making the government work better. Some 300 members of task forces, serving without pay, and another 200 experts in research have aided it in working out a plan. This plan aims to give better government at lower cost, to cut red tape and give good men a chance to perform, and to provide efficiency and simpler relations with citizens. Action rests with the Congress.¹

Only an aroused, supporting public opinion will, however, put the plan over. It is, therefore, heartening that leading citizens have started an organization, unique in the history of proposed reorganizations, which will support the Commission's recommendations, as counteraction against pressure groups with selfish interests opposing them. This most impressive body of important citizens is, as described by Mr. Hoover, "absolutely non-partisan, as witness former Vice President John Garner on one side and General Dawes (former

Vice President) on the other. It includes five former members of Democratic Cabinets and five members of former Republican Cabinets. It embraces the heads of the labor organizations, the farm organizations, chambers of commerce, tax associations, women's clubs, universities, publishers and many others."¹

The report recommending reorganization of federal medical activities seeks to unite the functions now in five major agencies—the medical departments of the Army, the Navy, the Air Force, the Veterans Administration and the Public Health Service—so as to eliminate overlap, waste and inefficiency. Other objectives are to provide "better medical care for the beneficiaries of the Federal Government's medical programs;" to create "a better foundation for training and medical service in the Federal agencies;" to reduce "the drain of doctors away from private practice;" to provide "better organization for medical research," and to promote "a better state of medical preparedness for war."

A United Medical Administration would be headed by an Administrator and three Assistant Administrators to be appointed by the President with the advice and consent of the Senate. An advisory board, consisting of the Surgeons General of the Army and Navy, the Air Surgeon, and the Administrator of Veterans Affairs or his representative, would advise the Administrator on policies, thus promoting a unity of services in the national interest. The Administrator would report directly to the President.

Others among the 11 specific recommendations

1. How to Save Four Billions a Year, an Interview with Herbert Hoover, U. S. News & World Report, June 3, 1949, pp. 22-26.

are that the "Congress should define the beneficiaries entitled to medical care from the Government and prescribe how this care should be given;" that "the present inconsistency in policy between the Federal hospital construction program and Federal aid to non-Federal hospitals under the Hill-Burton Act should be ended;" that "the control of medical policy in the armed services should be exercised by the Secretary of Defense;" that "the United Medical Administration should give constant attention to necessary measures for national defense;" that "medical and other technical personnel in the Administration should be on a career service basis;" that "a survey should be made to determine the needs for emergency aid to medical schools," and that "the highest priority in importance should be given to research, preventive medicine, public health, and education."

About one sixth of the nation receives in varying degree direct medical care from the federal government. Among some 24,000,000 beneficiaries approximately 18,500,000 are veterans; the remainder are from the military forces and other government agencies. More than 40 government agencies now render this federal medical service and they expect to expend this fiscal year nearly \$2,000,000,000. The need for reform would appear to be obvious to any informed citizen, regardless of political affiliation.

The Commission believes that a unified medical service would improve the general standard of federal medical care. With central supervision, the President, the Congress and the public could look to one man for results. The cost of health and medical services would be clearly identified and known to the Congress. Construction costs could be standardized and reduced. Elimination of present distinctions as to the particular types of beneficiaries for which each federal hospital can care would permit full utilization of federal hospitals. Whether a veteran, a merchant seaman, a soldier, a sailor or an airman, a patient is, after all, a patient.

Under this plan, full use could be made of the medical manpower at the call of the federal government, and there would be great reduction in the present deficits in skilled personnel. The need for any draft of medical manpower in time of peace would likewise be greatly lessened. Also, it would be possible to utilize far more effectively than at present the facilities of private hospitals and the skills of physicians in private life and in the universities.

What will become of the Hoover Commission Report? The ultimate disposition of its constructive recommendations is of vital concern to every citizen of this country. If the public insists and demands it, as Mr. Hoover has said, then the plans will be realized.

Wonderful Warriors The Doctors' Wives

The fruits of the kind of campaigning and practical educational work that will keep American medicine free were reaped in abundant measure here in Florida in April. At its annual convention in Hollywood, the General Federation of Women's Clubs emphatically took its stand against "Government control of health services" and for "the extension and development of Voluntary Health Insurance."

The resolution, adopted by a 2,000 to 3 vote, carried great import for it expressed the feelings of millions of women on the subject of sickness taxation. The General Federation, with its 16,500 clubs and 7,700,000 members, 5,000,000 of whom reside in this country, is one of the nation's most influential organizations. The impact of the practically unanimous action in this matter, despite all the pressure the Truman Administration could bring to bear, will long resound in the halls of the Congress and will have weight even in the White House.

The unwritten story behind the press notices is that doctors and doctors' wives throughout the country helped to make this victory possible. Doctors' wives who were delegates battled royally for the cause. Deserving special commendation is the Woman's Auxiliary to the Florida Medical Association for its on-the-spot assistance and excellent cooperation. The doctors' wives carry on admirably in the best American tradition.

Problems of Licensure of Foreign Medical Graduates

The licensure of physicians with medical degrees from foreign institutions promises to present a growing problem for the National Board of Medical Examiners and for the licensing bodies of the states and territories of this country. Because of unsettled economic and political conditions abroad, many physicians have come to the United States, and it is predicted that the number seeking to migrate will increase in the years ahead. In addi-

tion, each year a number of Americans, either from choice or because they cannot gain admission to an American college, enter foreign medical schools with the expectation of returning to the United States to practice.

The first of two basic principles involved in the licensure of physicians is the requirement, long recognized by all states and nations, that a physician satisfy a licensing body representing the public as to his competency before he is permitted to practice. This principle is essential for the protection of the public. The second principle is that the training a man has undergone in preparing to enter a profession is a paramount factor in determining the quality of his professional practice.

In pointing out these principles recently, the Committee on Foreign Medical Credentials,¹ sponsored by the Council on Medical Education and Hospitals of the American Medical Association and including representatives of nineteen organizations, emphasized as an important corollary of the second principle that the best assurance of the quality of the training of a physician is an intimate knowledge of the faculty, facilities, curriculum and standards of the medical school from which he has graduated. The present high standards of medical practice in the United States have resulted directly from recognition by the licensing boards that evaluation of the school from which a physician graduates is equally as important as evaluation of the physician himself. Reluctance of many state boards to admit foreign-trained physicians to examinations has been justified because medical education in many foreign countries has been inferior to medical education in this country.²

For many years the various state licensing boards have had the benefit of periodic thorough surveys of American and Canadian schools, carried out by the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges. It has, however, been beyond the resources of these two accrediting agencies to maintain current appraisals of the three hundred or more medical schools in other parts of the world. Owing to the few physicians, usually from well known foreign schools, who formerly migrated to the United

States, this lack of such inventory was not important until unsettled and unfavorable conditions abroad during the thirties brought large numbers of physicians to this country. During that period internal developments in many countries led to rapid deterioration in the quality of medical education. Then the catastrophic effects of the war caused medical education in other countries to degenerate to a shocking degree. Unsettled political and economic postwar conditions have not only prevented recovery, but so unsound and so inferior are the educational policies of some foreign countries that restoration of satisfactory standards of medical education seems unlikely in the foreseeable future.

Solving the problem of the foreign medical graduate without lowering the standards of American medicine and in a manner consistent with our national ideals of justice and humanitarianism places heavy responsibility on the licensing bodies and the governments to which they are responsible. The Committee on Foreign Medical Credentials wisely recommends that the various agencies concerned unite their resources and devise a satisfactory method for securing the detailed current knowledge of foreign medical schools which is indispensable for the guidance of state licensing boards in determining which foreign physicians have had sound training. As an added safeguard it is suggested that additional training in this country be required of a candidate for examination before a state licensing board whenever he cannot present evidence of being sufficiently familiar with recent scientific advances in medicine, with the practices and customs of American medicine and with the English language. By such measures, regulations can be developed which will be fair to the foreign graduate and adequate to protect the public.

This problem will in all likelihood confront the public, various legislative bodies and the licensing boards with increasing frequency during the next several years. That it has important and far reaching implications for the health and safety of the American people is obvious. Accordingly, the public should be provided with information to serve as a basis for intelligent opinion, and legislative and licensing bodies should be prepared to adopt an enlightened policy in deciding questions pertaining to the licensure of foreign-trained physicians.

1. Licensure of Foreign Medical Graduates, J. A. M. A. 139:1103-1104 (April 16) 1949.

2. Licensure of Foreign Medical Graduates, editorial, J. A. M. A. 139:1081 (April 16) 1949.

Dr. Palmer's Message

Of interest to the whole profession is the following excerpt from the presidential address of Dr. Bascom H. Palmer of Miami presented before the Florida Society of Ophthalmology and Otolaryngology at its tenth annual meeting held in Belleair on April 10:

"Since I possess no scientific knowledge uncommon to us all and do not feel sufficiently venerable, or senile, to impose upon you so-called fatherly advice, I should like on this occasion to emphasize the urgent necessity for this Society to take cognizance of, and accept its due share of, responsibility for the solving of the most vitally important problem confronting our nation today. There is so much being spoken and written about the socialization of the practice of medicine in the United States of America that it is difficult for the average layman to evaluate and to separate the good from the purely political, the true from the spurious.

"It is not my intent to propound to you the many valid reasons why government-administered medicine would redound to the detriment of the public and the professions alike, for we are well advised and require no added arguments to bolster our convictions. It is the misinformed public that is in need of the enlightenment we must proffer.

"Most certainly I have not the paranoiac's idea that I am capable of presenting to you any simple corrective formula, but I do believe that such a formula will not be forthcoming until we of the various branches of the medical profession bestir ourselves sufficiently to shake off our lethargy of self righteousness and discuss with our peoples the so-called advantages and benefits promised by our "give all" politicians, as well as the disadvantages and harmful results that we believe will inexorably follow the institution of bureaucratically administered medical practice. Furthermore, it is imperative that all concerned shall be informed by us in such a sincere, honest and straightforward manner, accepting responsibility for our shortcomings, that we cannot be misjudged as tainted with undue bias and selfishness. Such a program entails a difficult task, to be sure, but if our freedoms, yea, the freedoms of the entire nation, are to be preserved, we must not falter.

"Because I am firmly in accord with the wisdom of Winston Churchill's recent utterance in Boston that 'the machinery of propaganda may pack man's mind with falsehood,' it is propitious that we should now begin to displant those po-

litical false implantations with the truth that the Medical Doctor is now, as in fact he has always been, the true and unfaltering friend to humanity.

"The populace must be made to realize and understand that good health is not a matter of inalienable right; that ill health occurs to all, rich and poor, though more often to the poor, because those very politicians (the Peppers and the Ewings) who are attempting to force Socialized Medicine, and who are attempting to portray us as enemies of the people, have failed to provide that utopia where the poor can be better fed, clothed and housed, which is, of course, the contributing cause for so much disease and misery. Surely it is not we who need be shown that those intangible services of the physician to his patient are the product of individualized thought and cannot be dispensed by the same abstract routine as that of the clerk who sells a bar of soap or a pound of fish. Certainly our profession cannot be charged with those imperfections of society.

"My abiding faith is that the average American is an understanding fair-minded person, able and willing and anxious to judge properly and settle with a minimum of injustice any problem if given the truthful information upon which to base his decisions. So it is my plea to ourselves that we resolve to keep him believing that the Oath of Hippocrates is just as sacred to us as it ever was to our beloved forebears of those 'good old hosse and buggy days' and that it is held as inviolate by us today as it was by them in their day."

Maternal Mortality: United States, 1947

Maternal mortality decreased to a new low in the United States during 1947, according to figures released by the National Office of Vital Statistics of the Public Health Service, Federal Security Agency. The maternal mortality rate was 1.3 per 1,000 live births in 1947 as compared with 1.6 in 1946. The number of maternal deaths (associated with diseases of pregnancy, childbirth and the puerperium) also decreased from 5,153 deaths in 1946 to 4,978 in 1947, despite the tremendous increase in the number of births.

In 1947, the maternal mortality rate for white women was 1.1 per 1,000 live births, while that for nonwhite women was 3.3, or 3 times as great.

The risk of dying associated with childbearing has been declining steadily since 1933, the first year in which data are available for the entire

continental United States. From 6.2 in 1933, the maternal mortality rate decreased 79 per cent to 1.3 in 1947. Maternal mortality decreased more rapidly among white than nonwhite women. The maternal mortality rate for the white race decreased 80 per cent, from 5.6 in 1933 to 1.1 in 1947, and the rate for the nonwhite races decreased 66 per cent in this period, from 9.7 to 3.3.

For the individual states the maternal mortality rates in 1947 ranged from 0.6 deaths per 1,000 live births for residents of Minnesota to 2.6 for residents of Alabama, Mississippi, and South Carolina.

Graduate Instruction in Serodiagnosis and the Treatment of Syphilis

During the week of February 21, five evening sessions of graduate instruction in serodiagnosis and the treatment of syphilis were held consecutively in Miami, Tampa, Orlando, Jacksonville and Pensacola. The first hour of the program was devoted to a discussion of the serodiagnosis of syphilis with particular attention to the clinical interpretation of serologic findings. Both physicians and technical workers attended this session. In the second hour, the latest findings in the treatment of syphilis were considered with the physicians. The technical workers, at this time, met separately, devoting their attention to problems related to improvement of serology practice.

Dr. Charles Rein was one of the guest speakers. He is a leading syphilologist practicing in New York, is associated with New York University and Bellevue Hospital, is a consultant to the United States Public Health Service and during World War II, was Chief Serologist for the Army. He was joined by Dr. D. K. Kitchen, who is working currently with Dr. Evan Thomas and Dr. Rein at Bellevue Hospital in the assay and clinical evaluation of penicillin in syphilis therapy. Dr. Kitchen is also the Medical Director of the Bristol Laboratories. He thus has firsthand knowledge of the production, assay and clinical evaluation of penicillin. Dr. J. F. Henry, Medical Officer in Charge of the State Board of Health Rapid Treatment Center, Dr. Albert V. Hardy, Director, Bureau of Laboratories, and Miss Carolyn Roth, Chief Serologist, also contributed to the discussions.

Dr. Rein emphasized the urgent necessity of physicians being familiar with the variation in serologic tests currently being employed in different laboratories. He emphasized that there is no

entirely specific test; to be acceptable, a test must yield less than 1 per cent biologic false positive reactions. Furthermore, no test is sufficiently sensitive to detect syphilis in all cases. The major change in the rapidly changing field of serology is the progressive increase in the sensitivity of these tests. Dr. Rein obviously viewed with favor the newer "cardiolipin" tests set at a high level of sensitivity. The importance of quantitative tests was stressed. These are essential in the follow-up of penicillin-treated cases and are needed to measure significant variations in degree of positivity which would have diagnostic significance. Considering treatment, the general impression was that it is becoming progressively simpler and more effective. The time may not be far off when adequate treatment will be provided by a very limited number of injections given at intervals of two, three or more days. To serve his patients best, the physician must keep abreast of this advance knowledge.

The sessions in each of the five localities were well attended.

This graduate instruction was arranged in cooperation with the Department of Medicine of the Graduate School of the University of Florida, the Florida Medical Association and the Florida Association of Medical Technologists.

YOUR BLUE SHIELD

Annual Meeting

The annual meeting of the Active Members of the Florida Blue Shield Plan was held on April 10, in Belleair, in conjunction with the annual meeting of the Florida Medical Association. One hundred and sixty-nine Active Members who could not attend this meeting appointed proxies with voting power to represent them. Four doctors and three laymen were elected, from nominations submitted by the Florida Medical Association, to fill vacancies on the Board of Directors brought about by the expiration of seven terms of office. Those elected to serve three year terms of office on the Board of Directors are: Dr. Thomas H. Bates, Lake City; Dr. Edward Jelks, Jacksonville; Mr. W. E. Arnold, St. Luke's Hospital, Jacksonville; Mother Loretta Mary, St. Joseph's Hospital, Tampa; Dr. William C. Blake, Tampa; Dr. Walter C. Jones, Miami; and Mr. Spencer Locke, chairman of the National Health Insurance Committee of the National Association of Letter Carriers, Orlando.

Reports of President and Executive Director

Speaking on the growth of the Blue Shield Plan during 1948, Dr. Leigh F. Robinson, president, stated, "Since our meeting in Jacksonville last July, we have almost doubled our enrolment. Less than two years ago when we made our first report, our enrolment was 20,000. Last year at our annual meeting we reported an enrolment of 50,000, a gain of 30,000. This year, our third anniversary, we are pleased to report an enrolment of approximately 100,000, a gain during the past year of 50,000."

In reference to physician participation in the Blue Shield Plan, Dr. Robinson stated, "Last year at this time we had 1,271 participating physicians; we now have over 1,500 participating physicians. This figure represents about 75 per cent of the physicians of Florida. Every medical doctor of Florida should appoint himself a committee of one to persuade nonparticipating physicians to participate in this good work. The Florida Blue Shield is a product of the Florida Medical Association and its success depends upon the medical profession of Florida. Today, the medical profession of the United States may well appreciate that the Blue Shield Plans sponsored by the many state medical associations are the only constructive accomplishments that organized medicine has offered for the solution of our present medical economic problems. Without our state Blue Shield Plans and their national organization, the Associated Medical Care Plans and the Blue Shield Commission, the medical profession today would have nothing better to offer the public than have the sponsors for compulsory health insurance. With this thought in mind let us, the participating physicians, continue to support and cooperate with our Blue Shield in order that there can be no slowing down of our progress."

In his report to the Active Members, Mr. H. A. Schroder, executive director, advised that during 1948, the Blue Shield Plan paid \$315,731.76, or 73.3 per cent of every dollar received in membership fees, to participating physicians for the care of Blue Shield members.

Election of Officers

The annual meeting of the Board of Directors was held immediately following adjournment of the meeting of the Active Members. At this meeting Dr. Leigh F. Robinson of Ft. Lauderdale was re-elected president. Other officers elected

are Dr. Walter C. Jones, Miami, first vice president; Mother Loretta Mary, St. Joseph's Hospital, Tampa, second vice president; Dr. Herbert E. White, St. Augustine, secretary, and Dr. Frederick J. Waas, Jacksonville, treasurer.

Additional Benefit

Active Members were advised that the Board of Directors had approved the addition of medical care to the present surgical care contract. This additional benefit will allow \$5.00 per visit, with a limit of one visit per day, benefits to begin on the fourth day of hospitalization for patients who are hospitalized for care not in connection with surgery. Mr. Schroder stated that approval of this addition to the Blue Shield contract must be secured from the State Insurance Department and that these additional benefits would become effective approximately sixty days after such approval is received.

STATE BOARD OF HEALTH

Dr. Edward C. Love, Jr., of Quincy has resigned his position as health officer of the county health unit composed of Gadsden, Liberty and Calhoun Counties. Dr. Love plans to do post-graduate study.

Dr. H. A. Sauberli, director of the Leon County Health Department with headquarters at Tallahassee, has resigned as of June 10 to accept the position of director of Local Health Service, Colorado State Health Department.

Dr. William J. Peebles, formerly director of the Troup County Health Department, LaGrange, Ga., has accepted the position of director of the Monroe County Health Department with headquarters at Key West. He replaces Dr. James B. Parramore, who resigned because of illness.

Dr. J. C. McGuire, formerly director of the Copiah County Health Department, Hazlehurst, Miss., has accepted the position of director of the county health unit composed of Hardee, DeSoto and Charlotte Counties with headquarters at Arcadia. He succeeds Dr. James W. Ferris.

Dr. Holland M. Carter, director of the health unit composed of Madison and Taylor Counties with headquarters at Madison, has resigned to accept a position with the South Carolina State Board of Health. He will be replaced by Dr. James L. Wardlaw, formerly of Biscoe, N. C.

Dr. Paul W. Hughes, assistant health officer in Alachua County, has been elected health officer of Broward County with headquarters at Ft. Lauderdale. Dr. Hughes was to assume his new duties on May 15. He will be replaced in Alachua County by Dr. Montie E. Smith, Jr., of Selmer, Tenn.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical associations and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

J. Maxey Dell, Jr., of Gainesville, Jacksonville Beaches Kiwanis Club
 Richard C. Cumming of Ocala, local Lion's Club
 Kenneth Dunham of Frostproof, local Rotary Club
 F. Gordon King of Jacksonville, local chapter of the Sons of the American Revolution
 Allen E. Kuester of Cocoa, local Rotary Club
 John W. Vaughn of Lakeland, Auburndale Rotary Club
 Robert B. Harkness of Lake City, Live Oak Woman's Club
 Theodore J. Kaminski of Melbourne, local Kiwanis Club
 John D. Flynn of Tampa, local Kiwanis Club
 Ernest B. Milam of Jacksonville, local branch of the National League of American Pen Women
 Norman E. Williams of Daytona Beach, local members of Florida State Nurses' Association
 Richard C. Cumming of Ocala, local Kiwanis Club
 John R. Boling of Tampa, local Rotary Club
 John N. Sims of Live Oak, local Kiwanis Club
 Taylor W. Griffin of Quincy, local Kiwanis Club
 Ernest B. Milam of Jacksonville, local Business and Professional Girls' Club
 John N. Sims of Live Oak, local Rotary Club
 Herbert B. Lott and Samuel G. Hibbs of Tampa, local Exchange Club
 Kenneth Dunham of Frostproof, Arcadia Rotary Club
 Cleland D. Cochran of Daytona Beach, local Veteran's Business Men's Club
 James W. Sapp of Havana, local Kiwanis Club
 Bernard E. Kane of Crescent City, Palatka Kiwanis Club
 Herbert B. Lott of Tampa, local U. S. S. Post No. 5, American Legion
 John N. Sims of Live Oak, local Junior Chamber of Commerce
 Herbert E. White of St. Augustine, local Pilot Club
 Joseph S. Stewart of Miami, State Association of Accident and Health Underwriters in West Palm Beach
 Cleland D. Cochran of Daytona Beach, New Smyrna Beach Kiwanis Club

Members in Armed Services

Names and addresses of doctors in the Armed Services received since the last listing was published:

Duval

Swift, Edwin C.

Jacksonville

BIRTHS AND DEATHS

Births

Dr. and Mrs. James E. Blades, Sarasota, announce the birth of a daughter on April 28, 1949.

Dr. and Mrs. Francis D. Pierce, Ft. Lauderdale, announce the birth of a son, Robert, on Feb. 27, 1949.

Dr. and Mrs. Scottie J. Wilson, Ft. Lauderdale, announce the birth of a daughter, Carolyn Anne, on April 6, 1949.

Dr. and Mrs. Wilbur C. Sumner, Jacksonville, announce the birth of a son, Wilbur Clifford, Jr., on May 17, 1949.

Dr. and Mrs. Julian A. Rickles, Miami, announce the birth of a son, Thomas Jacob, on May 12, 1949.

Dr. and Mrs. Wade S. Rizk, Jacksonville, announce the birth of a son, Norman Wade, on May 21, 1949.

Deaths — Members

Dr. John T. Bradshaw, San Antonio May 22, 1949

Deaths — Other Doctors

Dr. Howard C. Von Dahm, Lake City May 28, 1949
 Dr. Claude L. Davis, Alma, Ga. May 21, 1949
 Dr. Irvin P. Philpot, Branford May 27, 1949
 Dr. Archibald B. McQueen, St. Petersburg Feb. 6, 1949
 Dr. Karl Friedbacher, West Allis, Pa. May 10, 1949
 Dr. Forrest E. Williams, Pacific Grove, Calif. Sept. 3, 1948
 Dr. Wm. M. McCormick, Falls Creek, Pa. Sept., 1948

STATE NEWS ITEMS

Dr. Webster Merritt, Assistant Editor of The Journal, was signally honored by the University of Florida on May 30 when he was initiated into Phi Beta Kappa. It is the policy of the University to choose two distinguished alumni each year for this high honor, one from the faculty and one from business or professional walks of life. This year, the choice fell upon former classmates, Dr. Merritt, who received the Bachelor's degree from the School of Arts and Sciences in 1929, and Professor W. G. Carlton, a law graduate of 1931.

Dr. Charles E. Aucremann of St. Petersburg has opened offices at 330 Beach Drive, North. He will limit his practice to internal medicine (gastroenterology). Dr. Aucremann formerly was associated with Dr. James L. Borland in Jacksonville.

The following members of the Florida Medical Association were registrants at the 30th annual session of the American College of Physicians which was held in New York City from March 28 through April 1: Drs. J. Sudler Hood, Clearwater; Norman E. Williams, Daytona Beach; Theodore F. Hahn, DeLand; Eugene C. Chamberlain, Ft. Lauderdale; James L. Borland, Turner Z. Cason,

Karl B. Hanson, Nathaniel Jones, Janet G. Leser, Robert H. Nickau, Walker Stamps, Jacksonville; Herbert Eichert, Robert M. Harris, E. Sterling Nichol, Benjamin G. Oren, Samuel W. Page, Jr., Harold Rand, Jack O. W. Rash, George F. Schmitt, Donald G. Stannus, Franz H. Stewart, Earl R. Templeton, Miami; Victor H. Kugel, Miami Beach; Fred Mathers, W. Dean Steward, Orlando; Fred E. Manulis, Palm Beach; Arthur H. Reynolds, Richard Reeser, Jr., St. Petersburg; William C. Blake, Joseph C. Flynn, H. Phillip Hampton, Richard C. Rodgers, J. Maxwell Williams, Jr., Tampa; W. Wellington George, West Palm Beach.

The Florida Heart Association was founded at a meeting in Belleair, April 10, 1949. It is affiliated with the American Heart Association. Membership in the Florida Heart Association is open to any member of the Florida Medical Association, and those who are interested are requested to contact Dr. Jere W. Annis, secretary-treasurer, Box 1021, Lakeland.

Dr. Walter G. Holloman of Jacksonville recently transferred his practice to Houston, Tex.

Dr. Ernest B. Dunlap, Jr., of Jacksonville has opened offices in Atlanta for the practice of medicine.

Dr. Rudolph W. Heath of Hollywood recently received a postgraduate course in endocrinology which was given at the University of Georgia School of Medicine.

Dr. Edwin H. Brown of Green Cove Springs has returned to his offices after doing postgraduate work at the University of Georgia School of Medicine.

Dr. Phillip W. Horn of Jacksonville was the guest speaker of the Springfield Woman's Club in April. He spoke on tuberculosis.

Dr. Charles C. Hillman of Miami has conducted a survey among the patients of the Jackson Memorial Hospital, of which he is director, designed to check the attitude of the patients toward the satisfaction of service received in the hospital.

Dr. Carl C. Mendoza of Jacksonville recently attended clinics in New Orleans.

Drs. Amelia B. Sheftall and Lawrence E. Geeslin of Jacksonville attended several clinics in Boston in April.

Dr. Horace R. Drew of Jacksonville, a life member of the Association, recently was presented a gold key by his alma mater, the University of the South, Sewanee, in recognition of his service to the school during the past fifty years.

Dr. Charlotte C. Maguire of Orlando is the newly-elected president of the Central Florida Mental Hygiene Society. She succeeds Dr. Robert L. Tolle, also of Orlando. Dr. John D. McKey was elected first vice president.

Dr. Vernon T. Lockwood of St. Augustine is scheduled to return in July from his tour of European hospitals and clinics. Dr. Lockwood left New York City on the Queen Mary on May 18. He planned to visit hospitals in England, Scotland, Norway, Sweden, Denmark, Western Germany, Austria, Northern Italy, Switzerland and France, and clinics in London, Glasgow, Edinburgh, Oslo, Stockholm, Copenhagen, Munich, Zurich and Paris.

Dr. Adrian M. Sample of Ft. Pierce is the newly-elected president of the local Rotary Club.

Dr. Robert E. Blount of Ft. Lauderdale is receiving a postgraduate course in obstetrics and gynecology in Georgia. He plans to study from three to six months.

Dr. Curtis H. Sory of Ft. Lauderdale attended a course in endocrinology at the University of Georgia in Augusta which began the latter part of May.

Dr. Charles C. Hillman of Miami recently addressed members of the Miami Shores Men's Club.

Drs. Jere W. Annis and S. Allen Clark of Lakeland participated in a series of four programs held in May by the First Baptist Church of Lakeland. In connection with the Youth and Family Life Conference, Dr. Annis spoke on "Keeping Fit for the Greatest Event," and Dr. Clark spoke on "Fundamental Elements in a Happy Marriage."

Dr. John N. Sims of Live Oak has returned to his practice after spending two weeks in Chicago where he received a postgraduate course in surgery at Cook County Hospital.

Dr. Harry S. Howell of Lake City recently addressed the graduate nurses of the local Veterans Administration Hospital. His subject was "Obstetrics."

Dr. S. Allen Clark of Lakeland recently received a short intensive course in "Vaginal Approach to Pelvic Surgery," given by the Cook County Graduate School of Medicine in Chicago.

Dr. Irwin S. Leinbach of St. Petersburg recently outlined the work of an orthopedic surgeon before members of the Clearwater Lion's Club.

Dr. E. Borland Gill of Miami has retired from active practice as of May 1 and has asked that his name be removed from the active medical staff of the Broward General Hospital, Ft. Lauderdale.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Domeier, Luverne H., St. Petersburg
Douglass, Lawton F., Eustis
Field, Richard D., Winter Haven
Galitz, Eli, Miami Beach
Gridley, Roger W., Orlando
Haney, T. Paul, St. Petersburg
Higgins, Robert D., Daytona Beach
Lanier, James C., Jacksonville
Polskin, Louis J., Lakeland
Schwartz, George R., St. Petersburg
Simmons, Melville M., Sarasota

COMPONENT SOCIETY NOTES

Alachua

Members of the Alachua County Medical Society on April 7 heard Dr. J. Maxey Dell, Jr., chairman of the society's program of public relations, point out the weaknesses of "Compulsory Health Insurance." He was introduced by Dr. Alva T. Cobb, president.

Following Dr. Dell's talk, Dr. G. W. Schwalbe, Gainesville dentist, spoke briefly on the fluorination of the Gainesville water supply.

The society met jointly with the Auxiliary.

Bay

At the March meeting of the Bay County Medical Society, Dr. Charles H. Daffin lectured on heart ailments and used four recordings of various heart sounds, murmurs and rhythm disturbances. Dr. George D. Geckeler of Temple University, Philadelphia, supplemented Dr. Daffin's lecture.

Attending the meeting were Drs. Daniel M. Adams, Jr., Chas. T. Barton, Charles H. Daffin, Donald S. Fraser, James E. Kerr, M. J. Lingo, Amsie H. Lisenby, Martle F. Parker, Franklin H. Reeder, William C. Roberts, and C. W. Shackelford. Dr. Jack Corbitt was a guest.

DeSoto-Hardee-Highlands-Charlotte-Glades

At the May meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, Dr. Marion W. Hester of Lakeland presented a paper on "Dacryocystitis," which was illustrated with movies of a tear sac operation.

Members present included Drs. Harold S. Agnew, Roland W. Banks, Godfrey L. Beaumont, Henry P. Bevis, Isaac W. Chandler, Hubert W. Coleman, Miles A. Collier, Merle C. Kayton, Carl J. Larsen, Gordon H. McSwain, Ruth M. Miller, Edwin C. Northup, Wesley S. Pyatt, Zaven M. Seron, John A. Simmons, James G. Smith, Jr., Stanley K. Wallace and Howard V. Weems.

Duval

The scientific program of the May meeting of the Duval County Medical Society was presented by Dr. Victor A. Hughes, who read a paper on cancer of the cervix, based on research which he had done at Barnes Hospital in St. Louis. The paper was discussed by Drs. James V. Freeman, Donald M. Baldwin, H. Bernard McEuen, Floyd K. Hurt, Max Suter and Nelson A. Murray.

Escambia

The Escambia County Medical Society entertained medical officers of the Army and Navy at a banquet meeting on May 10. Capt. W. D. Davis and Capt. W. E. Kellum and their staff from the Naval Air Station were guests. Dr. A. Carpausis of the United States Army Air Forces represented the medical officers at Eglin Field.

Lieut. W. E. Furr spoke on "Concepts in the Treatment of Varicose Veins." Commander F. A.

Butler presented an illustrated lecture on "The Diagnostic Problems in Chest Diseases," and Commander F. V. Burley spoke on "The Medical Aspects of Atomic Warfare."

Franklin-Gulf

Dr. Rudolph Bell of Thomasville, Ga., was the guest speaker at the March meeting of the Franklin-Gulf County Medical Society. He spoke on "Hematuria."

Lake

All members of Lake County Medical Society have paid Association dues for 1949.

Marion

The May meeting of the Marion County Medical Society was held at the Hotel Florida in Ocala. Dr. Henry L. Harrell reported on the refresher tuberculosis seminar which was held in Orlando in the early part of May. His report included many of the major points which were stressed at the seminar.

Members present at the society meeting included Drs. William H. Anderson, Hugh H. Barfield, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Edwin C. Hanson, Henry L. Harrell, Eaton G. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles, Eugene G. Peek, Jr., Robert E. Thompson, Thos. H. Wallis and Harry F. Watt. Dr. Charles H. Blandford was a guest.

Pasco-Hernando-Citrus

The May meeting of the Pasco-Hernando-Citrus County Medical Society was held in Inverness with Dr. Jere W. Kirkpatrick as host. Several members participated in the presentation of the scientific program. Dr. William B. Moon discussed the case of a 21 year old white male who died following a rupture of aortic aneurysm. Dr. W. Wardlaw Jones presented several interesting roentgenograms of fractures. Throat condition with secondary systemic manifestations were discussed by Dr. S. Carnes Harvard and Dr. Moon. Dr. Frank J. Farley presented an interesting case of purpura.

A general discussion of legislative measures pending in Tallahassee was held by the members. Those present included Drs. Donald G. Bradshaw, George R. Creekmore, Frank J. Farley, S. Carnes Harvard, Porter J. Hudson, W. Wardlaw Jones, Jere W. Kirkpatrick, William B. Moon and William H. Walters, Jr. Dr. Gail M. Osterhout was a guest.

Pinellas

The scientific program of the May meeting of the Pinellas County Medical Society consisted of a presentation of several case reports. Dr. Albert R. Frederick presided. Drs. Everett M. Harrison and Julio J. Guerra discussed a case of death by novocain in which four similar deaths occurred in one family. A deduction of inherited allergy was made.

Drs. J. Sudler Hood and James M. Stem reported a case of either chronic fibro-cystic disease of the pancreas or celiac axis disease. The case was discussed by Dr. Edward L. Cole, Jr.

Dr. M. Eldridge Black presented an operative case of abscess of the urachus. Dr. Guerra, who had seen the operation, discussed the case.

Polk

Dr. J. Brown Farrior of Tampa was the guest speaker at the May meeting of the Polk County Medical Society. He spoke on cancer of the throat and on a special operation for the hard-of-hearing patients.

Volusia

Dr. Harry E. Mock, prominent Chicago surgeon, while in Daytona Beach writing a book last winter attended the February meeting of the Volusia County Medical Society. The discussion provoked there by presentation of an alternate plan of federal aid to improve medical care became the basis of a letter addressed by Dr. Mock to the county medical societies throughout the nation entitled "Alternate Programs for Federal Aid to Improve Medical Care, a Letter to All County Medical Societies."

In the meeting and in the letter this distinguished member of the medical profession made entirely clear the folly of supporting any alternate plan of federal aid to medicine in opposition to the Truman health program, for support of any plan of federal aid whatsoever is "tantamount to a confession that the medical care which we have been giving the people is faulty or wrong and we need federal aid to correct the situation." He continued, "The fight for or against Socialized Medicine is upon us. Those confident that it will never come may be licked by overconfidence. Those among us who feel that some form of Socialized Medicine is inevitable and that we had, therefore, better give the people an alternate plan rather than the President's plan are already licked. The politicians would gladly accept this alternate plan, for it would be the biggest wedge they have ever

had to undermine the American way of life. . . . We have too much government in medicine already. We do not need federal aid to improve medical care. The medical profession has done an excellent job in improving the nation's health. If we will face frankly our shortcomings and correct these, the people will reject 'political medicine.'"

Warning that the profession is in danger of becoming top-heavy with specialists, Dr. Mock made a plea for more general physicians, imbued with the common sense concept of good medical and surgical judgment, willing and able to treat the "average run of patients and adequately trained to do so. His admonition was, "Restore to the people the time-honored 'family doctor' of American Medicine and every criticism of the profession will disappear, and Socialized Medicine will go by the boards just as 'free silver' did in Bryan's day."

OBITUARIES

Joseph Rodwell Carver

Dr. Joseph R. Carver of Branford was drowned in the Suwannee River on April 19, 1949, in his efforts to rescue his 2 year old daughter, Kathryn Ann, also a victim of the overturned speed boat in which they were riding.

Dr. Carver was born in Decatur, Ga., in 1919. He attended elementary schools in Atlanta, and also was a student at Emory University. In March 1947, he was graduated from the University of Georgia School of Medicine in Augusta. Dr. Carver served a rotating internship at the Baroness Erlanger Hospital in Chattanooga, Tenn. He had only recently moved to Branford from Dalton, Ga.

The young physician was a member of the Madison-Suwannee County Medical Society, the Florida Medical Association and the American Medical Association.

Survivors include his widow, Mrs. Rebecca Carver, and two daughters.

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National Education Campaign

The county auxiliaries throughout the state are devoting their attention to the National Education Campaign. Of course, there is an over-all program for our coming year's work, but the emergency of compulsory health insurance is one which must of necessity receive our immediate attention.

The chairmen of the county auxiliary Education Committees, or Public Relations Committees, are organizing the work so that every doctor's wife is oriented into the "know-how" of approaching the public. Since getting the State and General Federations of Women's Clubs to pass resolutions opposing compulsory health insurance, we are now focusing our attention to other organizations. The members of the auxiliaries are obtaining as many letters and cards as possible from registered voters stating their opposition to this form of legislation. These letters and cards are to national legislators and the President of the United States.

Every doctor's wife in this state is urged to study the material on compulsory health insurance which has been distributed. She should be prepared to discuss intelligently her reasons for opposing such legislation.

Mrs. James L. Anderson,
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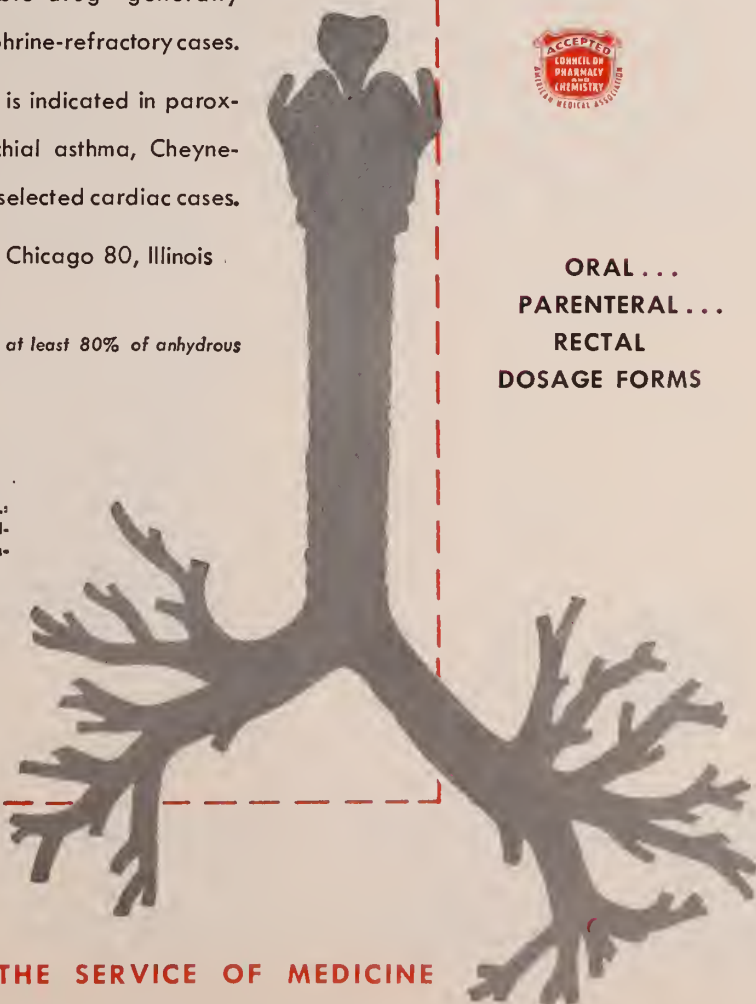
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1. Rackemann, F. M., in Cecil, R. L.: Textbook of Medicine, ed. 7, Philadelphia, W. B. Saunders Company, 1948, p. 539.



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BOOKS RECEIVED

REVIEWS OF MEDICAL MOTION PICTURES AND LIST OF FILMS AVAILABLE THROUGH THE MOTION PICTURE LIBRARY, AMERICAN MEDICAL ASSOCIATION. Prepared and procurable on request from: Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

This first revised edition of this booklet includes all of the medical motion picture reviews published in the Journal of the American Medical Association to Jan. 1, 1949. It has a classified table of contents and lists the films available through the Motion Picture Library of the American Medical Association.

The purpose of these reviews is to provide a brief description and an evaluation of motion pictures available to the medical profession. Frank, unbiased comments representing the considered opinion of competent authorities are intended to assist in taking some of the guess work out of ordering films for showing at medical society meetings. The motion pictures reviewed are, however, neither approved nor disapproved by the American Medical Association. Those distributed by the American Medical Association are listed on pages 77-95 of the booklet.

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XX

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Surgical Anatomy & Clinical Surgery, Two Weeks, starting July 25, August 22, Sept. 26.

Surgery of Colon & Rectum, One Week, starting September 12, October 10.

Esophageal Surgery, One Week, starting Oct. 10.

Thoracic Surgery, One Week, starting October 3.

Breast & Thyroid Surgery, One Week, starting October 10.

Fractures & Traumatic Surgery, Two Weeks, starting October 3.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 26, October 24.

Vaginal Approach to Pelvic Surgery, One Week, starting September 19, November 7.

OBSTETRICS—Intensive Course, Two Weeks, starting September 12, November 7.

MEDICINE—Intensive General Course, Two Weeks, starting October 3.

Gastroenterology, Two Weeks, starting Oct. 24.

Gastroscopy, Two Weeks, starting July 18, September 26.

Electrocardiography & Heart Disease, Two Weeks, starting July 18.

Electrocardiography & Heart Disease, Four Weeks, starting September 7.

PEDIATRICS—Personal Course in Cerebral Palsy, Two Weeks, starting August 1.

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by Joe Marsh

How's Your Listening Time?

Buck Howell and I were in Baleville last week. Dropped in at Bob's diner where some friends were sitting around talking about whether to sell their hogs now or wait.

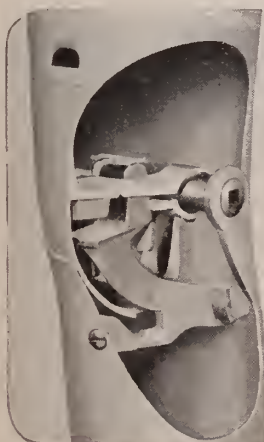
Right away, Buck plunges right into the discussion. He's lecturing away when suddenly they all stand up and start stomping their feet like it was an Indian war dance.

I'm flabbergasted. But Buck only looked sheepish: "Guess I was talking again, when I should-of been listening. When a person's talking time gets out of line with his listening time around here, the gang reminds him by standing up and stomping."

From where I sit, that's a good system. Everyone has a right to his opinions—but others have a right to *theirs*—whether it's deciding between to sell or not to sell, apple or cherry pie, or a glass of beer or cider. Life's more interesting that way, and hang it if you don't sometimes learn something!

Joe Marsh

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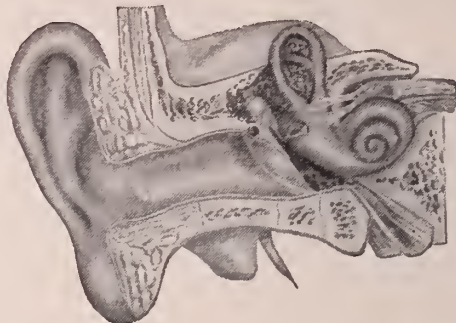
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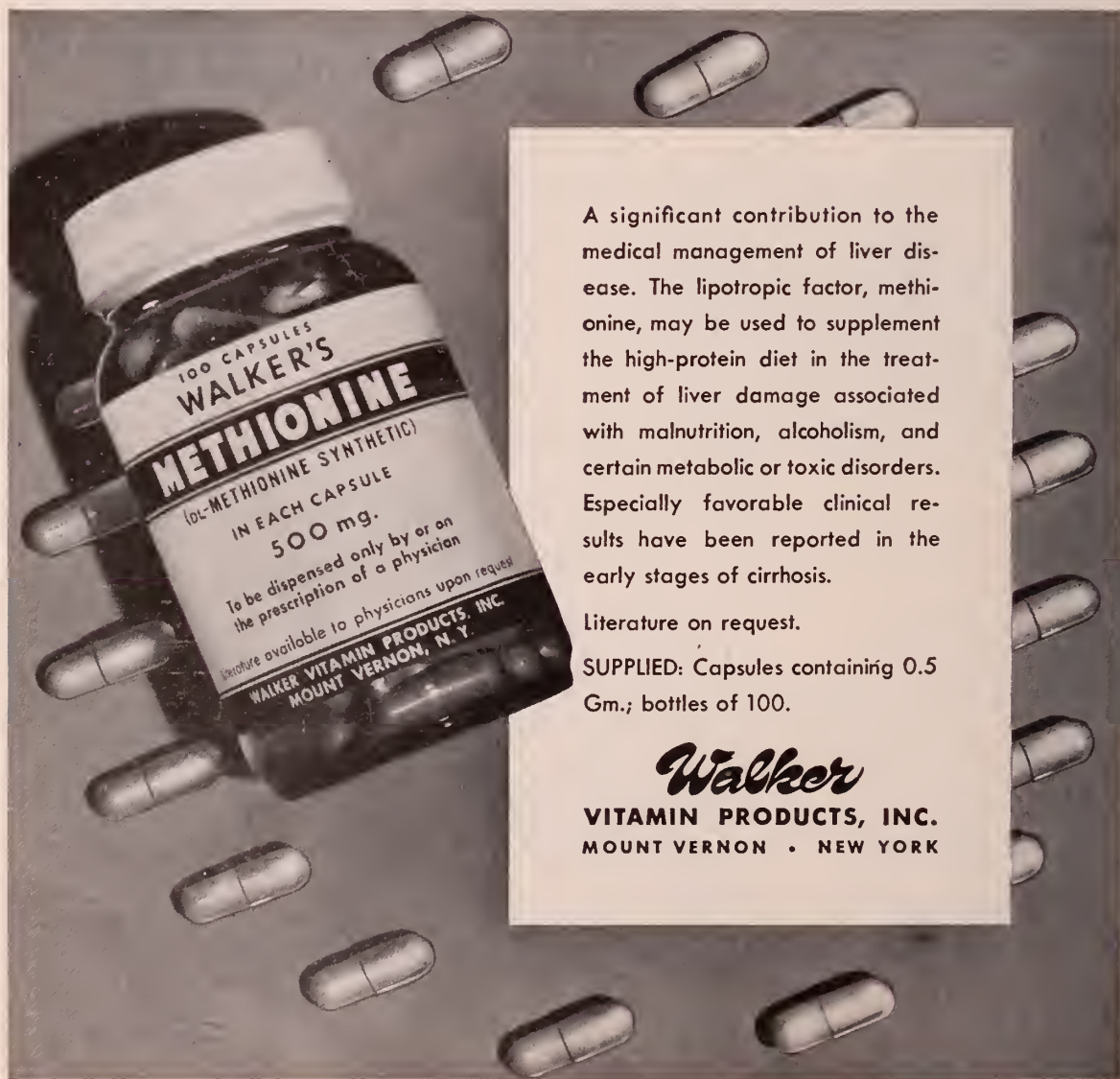
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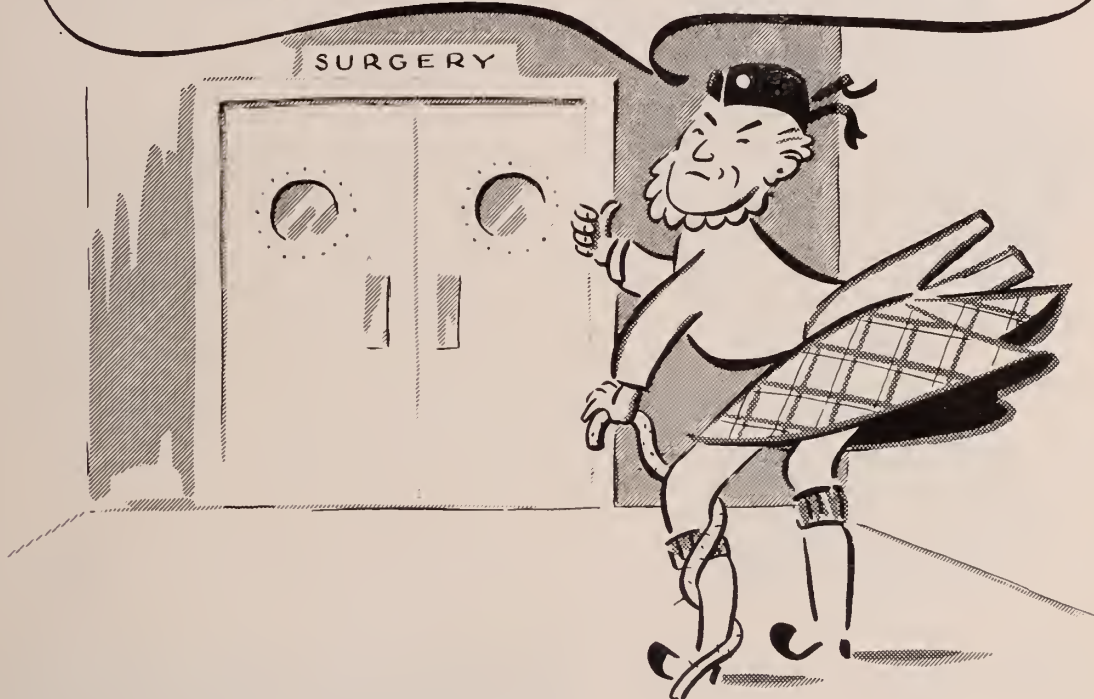
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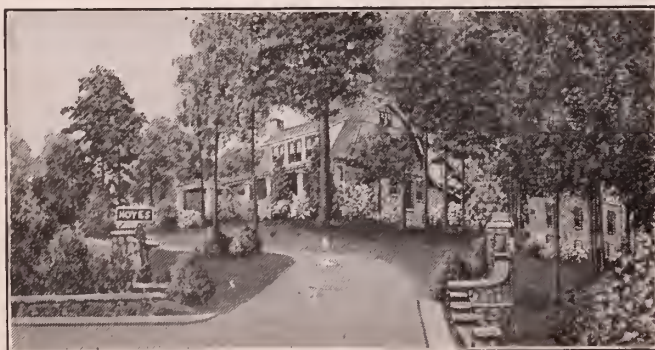
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville.....	Hollywood, Apr. 23-26, 1950
Florida Medical Districts.....	Russell B. Carson, Ft. Lauderdale	Council Chairman	
Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Quincy, 1949
Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Palatka, 1949
Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Sebring, 1949
Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	Ft. Lauderdale, 1949
Florida Specialty Societies			
Term. and Syph., Soc. of	A. Buist Litterer, Miami.....	Wesley W. Wilson, Tampa	Hollywood, Apr. 23, 1950
Enl. Practice of Med.	M. Crego Smith, Clearwater	Walter E. Murphree, Gainesville.....	" "
Health Officers' Society	Roger F. Sondag, Jacksonville.....	Lorenzo L. Parks, Jacksonville	" "
Industrial & Railway Surgeons	F. Hardy Bowen, Jacksonville.....	J. H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James G. Lyerly, Jacksonville.....	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Chas. J. Collins, Orlando.....	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	Bascom H. Palmer, Miami.....	W. Jerome Knauer, Jacksonville.....	" "
Orthopedic Society	Charles B. Mabry, Jacksonville.....	Eugene L. Jewett, Orlando	" "
Pathological Society	James N. Patterson, Tampa.....	Gretchen V. Squires, Pensacola	" "
Pediatric Association, State	Edgar W. Stephens, W. P. Beach	Hugh A. Carithers, Jacksonville	" "
Otolologic Society.....	Dean W. Hart, St. Petersburg.....	Frederick E. Farrer, Miami	" "
Radiological Society	James F. Pitman, Lake City.....	Floyd K. Hurt, Jacksonville.....	" "
Urological Society.....	Milton M. Coplan, Miami.....	Russell B. Carson, Ft. Lauderdale.....	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando.....	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman.....	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine.....	Hollywood, Apr. 23, '50
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa.....	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach
Public Health Association	Turner E. Cato, Miami.....	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami.....	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, April, 1950
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	R. L. Sensenich, South Bend, Ind.	Geo. F. Lull, Chicago	
Southern Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loran, Birmingham.....	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery.....	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of.....	Enoch Callaway, La Grange, Ga.....	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
S. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.....	Mr. L. H. Gunter, Montgomery.....	April 5-7, 1950
Southeastern Allergy Assn.....	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., 1950
Southeastern, Am. Urological Assn.....	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale.....	Edgewater Park, Miss., Feb. 1-5, '50
Southeastern Surgical Congress	R. J. Wilkinson	B. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
West Coast Clinical Society.....	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	Pensacola, Oct. 6-7, '49

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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	Martie F. Parker, M.D. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		15	10	A-1-50 William P. Hixon, M.D. Pensacola
	Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	61	54	
	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	7	6	
	Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	19	17	
	Walton-Okalosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
	.....	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%
	Columbia *Baker-Hamilton	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	44	42	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Joshua M. Price, M.D. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		5	100%	
	Suwannee	A. Franklin Harrison, M.D. Madison	Merwin E. Buchwald, M.D. Madison		5	100%	
	Madison	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	195
	Taylor *Dicke-Lafayette						
B	Alachua *Bradford, Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	40	100%	B-3-50 Charles C. Grace, M.D. St. Augustine
	Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	246	222	
	Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	28	26	
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McLane, M.D. Fernandina	Last Friday 8:00 P.M.	7	100%	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	.....	Charles E. Russell, M.D. 16 Magnolia St. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	14	100%
	Lake *Sumter	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	20	100%	
	Orange *Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	135	129	
	Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
	Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	55	54	583
C	Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	152	150	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	21	18	
	Pasco-Hernando- Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	11	100%	
	Pinellas	Francis H. Langley 190 18th Ave. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	163	162	
	Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	26	23	
	DeSoto-Hardee- Highlands- Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	29	28	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	Lee *Collier, Hendry	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	23	21	
	Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	79	75	
	Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	90	87	
D	St. Lucie- Okeechobee- Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megua, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	13	11	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	64	62	
	Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 628 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	511	459	D-8-51 S. Marion Salley, M.D. Miami
	Monroe	Frank E. Bowser, M.D. 420 Simonton St. Key West	Wallace H. Mitchell, M.D. 217 Duval St. Key West	2nd Thursday 8:00 P.M.	14	100%	
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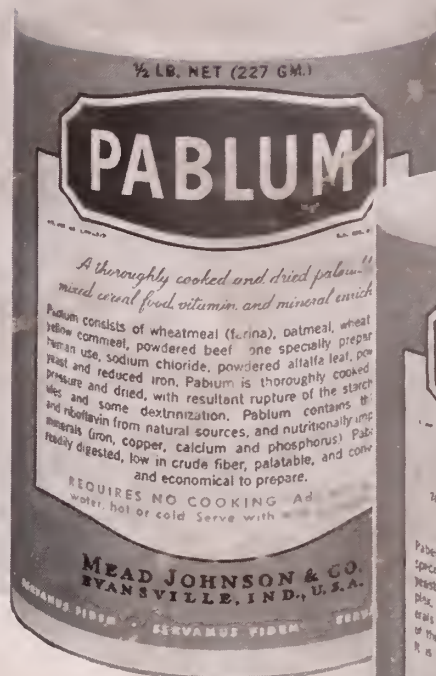
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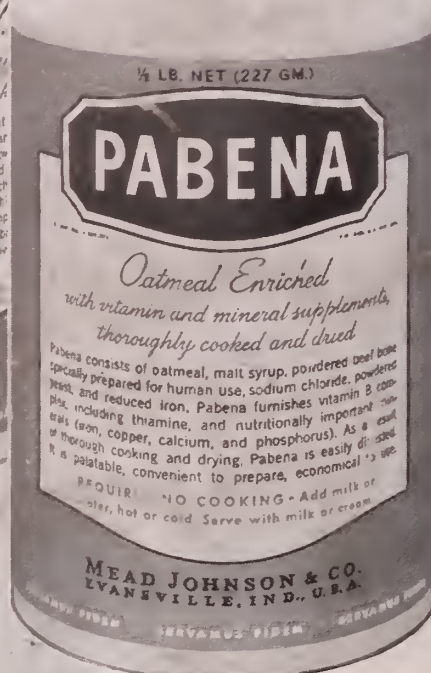
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

AUGUST, 1949

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IN THIS ISSUE

Heart Disease

Spencer A. Folsom and William H. Kelley



Sympathetic Nervous System

James G. Lyerly



Acute Anterior Poliomyelitis

William H. Izlar and John E. Wright



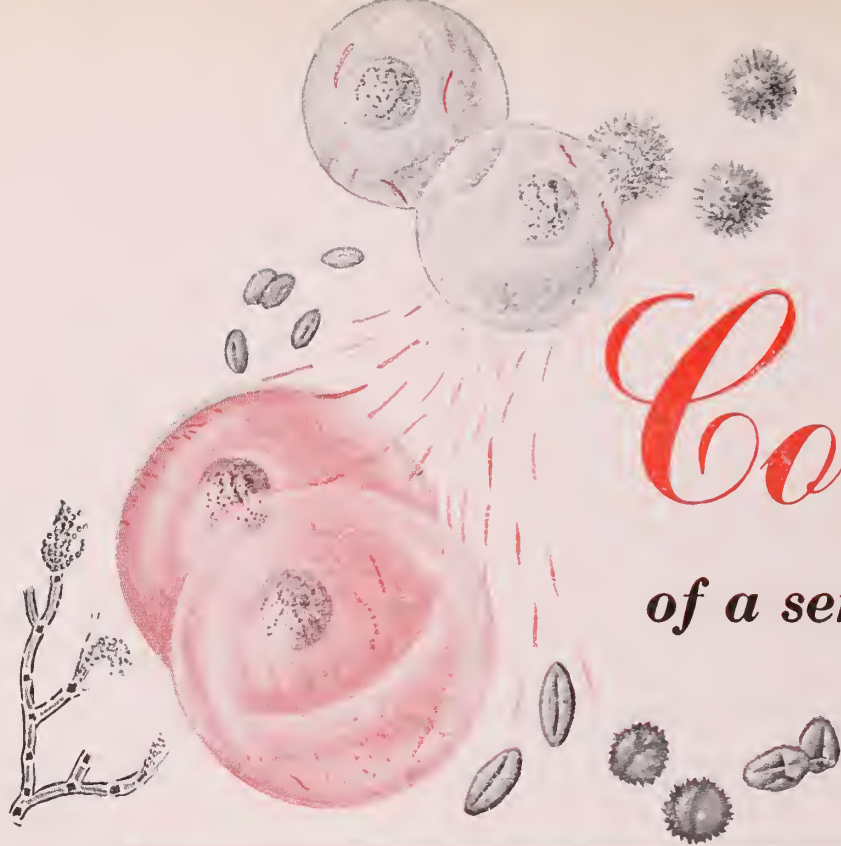
A Contribution to the History of Medicine in Florida

An Editorial

(Complete Table of Contents Page 68)

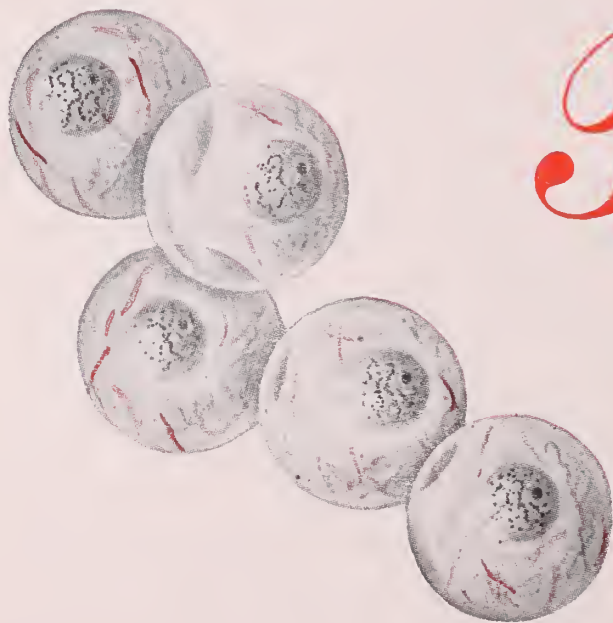
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Volume XXXVI

AUGUST, 1949

No. 2

CONTENTS

SCIENTIFIC ARTICLES

Heart Disease: a Clinical Evaluation, Spencer A. Folsom, M.D., and William H. Kelley, M.D.	83
Hematuria: Its Clinical Significance, Clarence G. Bandler, M.D.	86
Remarks on Surgery of the Sympathetic Nervous System, James G. Lyster, M.D.	90
The General Practitioner Today, R. B. Robins, M.D.	95
Acute Anterior Poliomyelitis: Case Report with Comments on Therapy, William H. Izlar, M.D., and John E. Wright, M.D.	98—

EDITORIALS

More About Naturopaths and Naturopathy	102
A Contribution to the History of Medicine in Florida	103
Dr. Elmer Lee Henderson, President-Elect of the A. M. A.	104
Dr. Seale Harris Honored	105
Church Group Decries Socialized Medicine	105

COMMENTARIES

1949 A. M. A. Convention	106
Graduate Courses Held	106
Education Campaign Materials	107

GENERAL FEATURES

Officers and Committees	100, 101
Medical District Meetings	85, 100
Your Blue Shield	108
State Board of Health	109
National Education Campaign	110
Births and Deaths	110
State News Items	110
New Members	111
Component Society Notes	111
John Thomas Bradshaw (Obituary)	112
Books Received	112
Schedule of Meetings	121
List of County Medical Societies, Presidents and Secretaries	122

This Journal is not responsible for the opinions and statements of its contributors.

FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

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Your personal help is needed to avert a serious threat to our national security!

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

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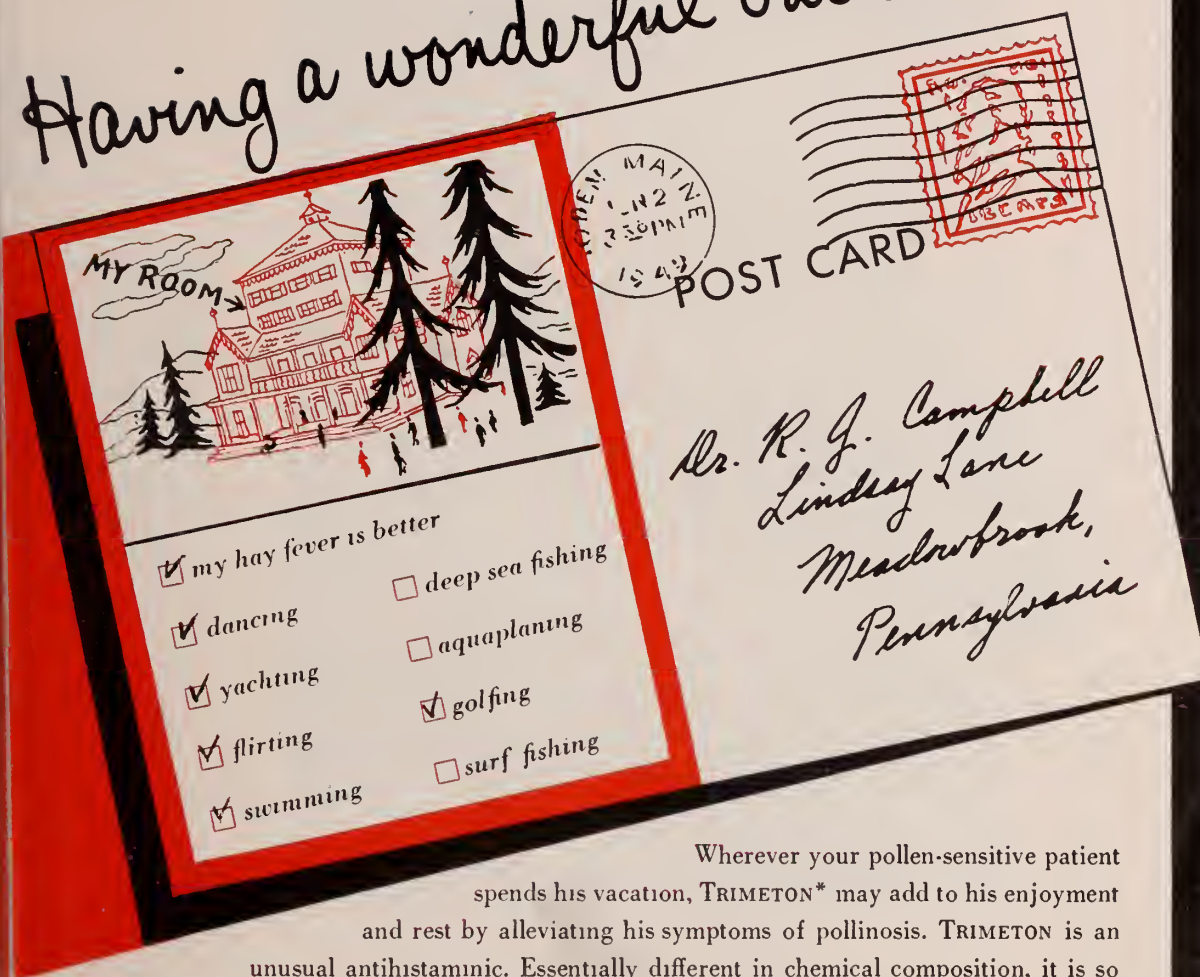


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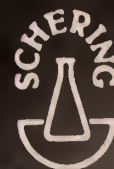
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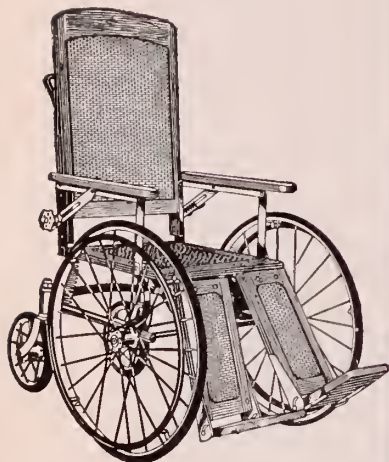
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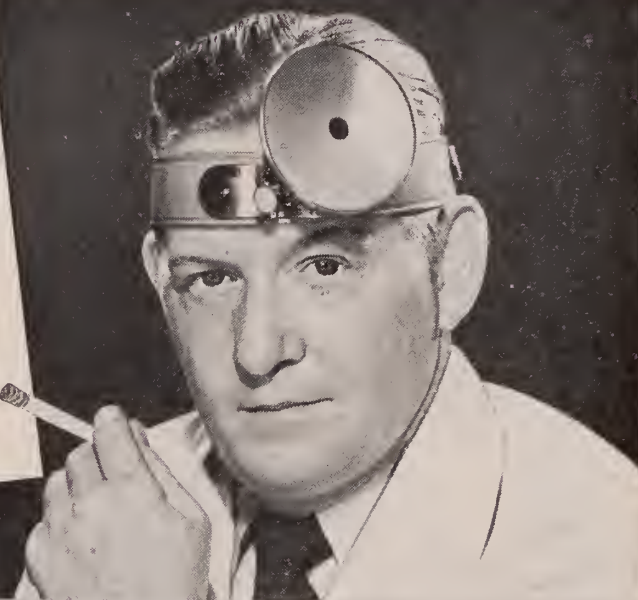
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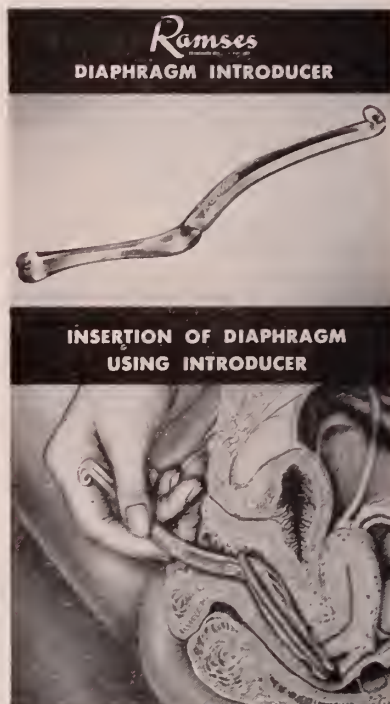
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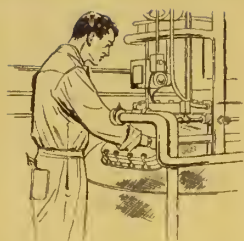


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Heart Disease: a Clinical Evaluation

SPENCER A. FOLSOM, M.D.*

AND

WILLIAM H. KELLEY, M.D.

ORLANDO

Pneumonia, as the "captain of the men of death," has been replaced by heart disease as the chief maimer and killer of the population. Woe-fully publicized in the past, and only lately recognized as a national menace, heart disease is still so little known to even the most intelligent layman that this diagnosis of his complaint strikes him with terror and foreboding. This is a condition that should be corrected.

A clinician can only be a good diagnostician by the use of his special senses and a sound clinical knowledge of the problems that confront him. Laboratory and mechanical aids are assuming a primary importance when they should play a secondary role.

The patient himself has not changed with the passing years; he still presents the same subjective symptoms and objective signs that he did in the days of Allbut, Osler and Cabot. The physician is the one who has changed, and he has changed because time has become more limited and his work is being done under greater pressure. It is much less time-consuming to order the limit of laboratory procedures and mechanical aids than to listen to the patient's story and take a good history. There are, however, many pitfalls in pursuing such a course. It has been often and truly said, "Let me take the history, and I don't care which good intern makes the physical examination."

Major considerations are:

1. A diagnosis of heart disease should not be made unless all the evidence is conclusive. It is easy to label a case but difficult to unlabel one.
2. Interpret in detail the presenting symptoms of fatigue, dyspnea, nocturnal dyspnea, ankle edema, cough and so-called indigestion.
3. Do not make a diagnosis of heart disease with a stethoscope alone because there is a murmur, premature contractions or tachycardia.
4. Beware of the diagnosis of coronary disease

in a woman under sixty years of age unless she has diabetic, syphilitic or hypertensive disease. This is not a golden rule but a good one to remember.

The great majority of cardiac lesions divide themselves readily into four great groups—the so-called rheumatic hearts, the syphilitic hearts, the hypertensive hearts and the arteriosclerotic hearts. We are leaving out of consideration congenital heart lesions and such as are due to disturbances of cardiac innervation, thyrotoxicosis, pericarditis, and so forth.

The Rheumatic Heart

The rheumatic heart is the heart of a young person who has had some acute infection from which the cardiac malady is dated. It may be chorea in childhood, or even scarlet fever, though the latter is unusual. It is more frequently tonsillitis, sore throat, a "cold," or an acute rheumatic fever. The first sign of its presence is a slight systolic blow heard in the mitral area and transmitted toward the axilla. It is transmitted in this direction because it is made in the left side of the heart, which lies behind the right side of the heart. The murmur cannot come through to the anterior wall of the chest because it is padded off by the right side of the heart, which is in front. It can escape, however, up into the armpit from underneath the heart, and so may be transmitted into the back of the chest. Thus one hears such mitral murmurs in two localities, the left axilla and left side of the back. The heart may heal in this condition. The patient may for the rest of his life have nothing but the remains of the mitral insufficiency, but, unfortunately, in the great majority of cases an extension of the original disease takes place, and in the course of time, sometimes in a few years, there is added to the original mitral insufficiency a mitral stenosis.

Nor does the process stop here. Frequently there occurs an extension of the inflammation to the aortic valves. If such an extension takes place, the pathogenesis is always the same. There

*Dr. Folsom died on June 26, 1949.

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 12, 1949

is first the production of an aortic insufficiency which may heal and remain healed indefinitely, or the morbid process may go on to the production of an associated aortic stenosis.

In mitral insufficiency a characteristic feature is a comparatively normal pulse. In mitral stenosis the pulse is profoundly affected both as to rate, rhythm and quality because the inflammation of the mitral flaps often spreads to the bundle of His. A mild degree of heart block may be present in cases of well compensated mitral stenosis.

In most cases, therefore, a glance at the patient will lead to the shrewd inference of the probable presence of a rheumatic heart on the one hand, or a renal, syphilitic, or arteriosclerotic heart on the other. His age will go far in leading to a preliminary determination. Also, his history will tell a great deal. If he has a heart which bothered him in earlier life or for years, or which has interfered with his getting insurance during the third decade of life, it is almost certain that the patient is suffering from a rheumatic heart.

The Syphilitic Heart

A syphilitic heart, to adopt a Hibernicism, is not a heart at all; it is an aorta. Of course, syphilis does affect the heart when there is produced a syphilitic myocarditis. Sometimes a syphilitic myocarditis crops up some years after the initial lesion, usually as a dyspnea of sudden, mysterious origin occurring in an adult somewhere around the fortieth year, who has been previously perfectly sound as to his heart. Such a sudden onset of dyspnea associated with rapid heart action in a man in the forties ought always to raise in the examiner's mind a suspicion of specific origin.

As already stated, however, a syphilitic heart is, in general, an aorta. By that we mean to say that when the spirochetes attack the cardiac mechanism, they really first attack the aorta. They seem to have a predilection for the ascending portion, though they often, of course, attack the transverse and descending portions and, indeed, any or all of the arteries of the body.

Syphilis is a great dilator. Its effect is invariably to widen the aortic arch, to produce a weakening of the aortic wall, with subsequent stretching. It is a dilator par excellence. The dilation may be so slight as to justify merely the diagnosis of a dilated arch, or it may be great enough to merit the diagnosis of aneurysm of the fusiform type. Often it is a matter of taste with

the examiner whether he shall designate a case syphilitic aortitis with dilatation, or syphilitic aortitis with aneurysm. There is no hard and fast line of demarcation between the two conditions. If the patient lives long enough, the dilatation leads to aneurysm.

When the spirochetes invade the aortic arch, they not infrequently invade also the aortic valves, and when they do, they always adhere to their law of dilatation. Their effect upon the aortic valves is invariably to produce an aortic insufficiency. There is absolutely no such thing as syphilitic aortic stenosis. It is wholly contrary to the law of syphilitic pathology. If one has reason to suspect the existence of aortic stenosis in a case, if, for example, the criteria of Von Leube are present and the pulse is tardy and small, then probably the diagnosis is wrong and the case is one of rheumatic instead of syphilitic disease.

There is another interesting phenomenon connected with the syphilitic heart, and that is the frequent association of coronary disease with syphilitic aortitis. Allbut insisted early upon the relative frequency of incipient syphilitic aortic infection in angina pectoris.

In whom do we find the syphilitic heart? We find it in men and in some women in the fourth and fifth decades of life. The story of almost all of them is that they have been well all of their lives as to their heart until comparatively suddenly, within a year or so, an almost complete cardiac breakdown has occurred.

The Hypertensive Heart

This is the heart of the person who has reached middle adult life. It is the *cor bovinum*. It is the heart of high blood pressure. Acute nephritis, of any type, does not give rise to the so-called renal heart. The renal heart is the product of chronic arteriosclerotic nephritis and of high blood pressure. It is the hypertrophied heart, the heart with an especially large left ventricle, the heart with a ringing aortic second sound due to the high degree of back pressure in the arteries. It is the heart which occurs in cases of polyuria, in cases in which the urinary output in the night exceeds the urinary output in the day. It is not the heart which shows many murmurs, for in the vast majority of cases none are noted until the stage of dilatation from overstrain due to high blood pressure is reached. It is not a difficult heart to recognize.

The Arteriosclerotic Heart

The arteriosclerotic heart is the heart of the aged. The person need not be aged in the sense that he is old in years, but must be aged in the sense that he is old in his arteries. He is the patient with great tortuosity of the temporal arteries, the patient who has begun to lose weight or who is already underweight, the patient with the moving brachial arteries and tortuous radials. Not infrequently the blood pressure is not especially high. In many instances it may not be much above 130 mm. systolic, but he betrays the arteriosclerosis in other ways. It oftentimes affects the coronary arteries or the brachial arteries, and not infrequently the renal arteries. It affects the whole body, leaving it undernourished and causing a gradual loss of weight. It is usually a comparatively easy matter in looking at the patient who complains of his heart to tell whether he belongs to the arteriosclerotic type or not. His appearance and age alone carry great weight in the final estimation.

These are, in short, the fundamental principles to be kept in mind when one approaches a cardiac case. They oftentimes simplify a problem which would otherwise be complicated.

Summary

Heart disease leads all diseases as a cause of death.

The laity have not been intelligently told about heart disease and, therefore, dread the very name.

Clinicians should use the five senses and make a diagnosis by clinical means first.

Some rules for the diagnosis of heart disease are mentioned.

Rheumatic, syphilitic, hypertensive and arteriosclerotic forms of heart disease are discussed from the clinical viewpoint.

319 American Building.

Discussion

DR. JERE W. ANNIS, Lakeland: Certainly, of recent years physicians have devoted considerable time to the newer technics and methods of investigation of cardiac disease to the exclusion of clinical evaluation which is of paramount importance. We should recall our attention to the physiologic condition as reflected in the clinical symptoms. This clinical evaluation does not stop at the diagnosis of cardiac disease, but extends to how the patient shall live and what he should do to produce the maximum of efficiency. Perhaps we feel rather less adequate in the field of management than in the field of diagnosis. It seems to me that we need to re-examine our old rule of thumb regimes on a clinical basis. We must, as Dr. Folsom pointed out, remember we are not dealing with an isolated condition, but with a patient. Our conclusions cannot be based upon or obtained from any routine procedure, but need to be based on our observations of the clinical picture at hand.

Medical District Meetings

The chairman of the Council, Dr. Russell B. Carson, has just announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Quincy, 2:30 p.m., Monday, Oct. 24, 1949

Palatka, 2:30 p.m., Wednesday, Oct. 26, 1949

Sebring, 2:30 p.m., Thursday, Oct. 27, 1949

Ft. Lauderdale, 2:30 p.m., Oct. 28, 1949

Hematuria: Its Clinical Significance

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One of the outstanding symptoms of urologic disease is blood in the urine; whether this is gross or microscopic makes little difference, although grossly bloody urine may be very alarming. It must be stressed that the finding of a few red blood cells on microscopic examination of the urine may be just as serious to the patient as massive hematuria. A casual urine specimen should contain no red blood cells; red cells in the urine are abnormal in contradistinction to the normal presence of a few white blood cells in a voided urine specimen.

Unfortunately, however, hematuria is disregarded or underestimated by the patient and also, all too frequently, by his physician. When hematuria appears grossly, the patient is generally sufficiently alarmed to seek medical care. When, however, the hematuria is of intermittent character, the patient may be lulled into a false sense of security and he may assume he is well. The physician, on the other hand, must recognize that this temporary disappearance of bleeding is no indication of the disappearance of its causative lesion, and that complete investigation of the urinary tract may be necessary to disclose that lesion. It is, perhaps, unnecessary to emphasize that the presence of blood in the urine is, in itself, not a clinical entity or a disease; it serves only as a sign of existing pathologic change which may require exhaustive investigation before its cause is determined.

Whether hematuria is the outstanding and presenting symptom, whether it is associated with other symptoms, or whether it is an asymptomatic finding of the laboratory examination does not alter its importance. The presence of other complaints such as pain, urinary frequency and burning may cause the patient to seek medical advice earlier than does the recognition of blood in the urine, although from the urologic point of view, the latter may be more serious. Concomitant symptoms may be chills and fever, sweats, loss of weight; indeed, symptoms referable to other body systems may be prominent, yet the problem may lie in the urinary tract and may be manifested solely by microscopic hematuria. A statistical

study of 2,240 cases of hematuria, made by MacKenzie of the Royal Victoria Hospital of Montreal, disclosed some interesting findings:

(a) Approximately one fifth (20.24 per cent) of all patients admitted to the urologic service of that hospital voided urine containing blood.

(b) In 96 per cent of the cases in which hematuria was present, a causative lesion was found in the urinary tract; in 4 per cent of the cases there was an extraurinary lesion which accounted for the blood in the urine.

(c) In 40 per cent of the cases of hematuria, the urologic lesion was found to be neoplastic. Other major causes were infection and lithiasis.

A similar study by Kretschmer of Chicago of a large series of cases of hematuria (935) gave similar findings. Reports by many authors have shown convincingly that blood in the urine is a serious symptom or finding, and that its cause or source must be discovered even though the search may necessitate extensive investigation, both clinical and laboratory.

Frequently, the anatomic site of the bleeding may be suggested by the character of the bleeding; that is, initial and bright bleeding may be due to anterior urethral disease; terminal hematuria may be due to a lesion of the posterior or prostatic urethra; total hematuria is more often from the bladder, ureter or kidney. Such evidences, however, are not sufficiently diagnostic, and only complete urologic survey will ascertain the location of the pathologic lesion.

Classification or grouping of the causes of hematuria is often useful in orderly thinking and discovery of the etiology of blood in the urine. There are four broad classes of bleeding from the urinary tract:

Table 1.—Classification of Hematuria

- I. Hematuria due to systemic disease
- II. Hematuria due to intrinsic diseases of the urinary tract
 - A. Renal
 - B. Ureteral
 - C. Vesical
 - D. Bladder neck and posterior urethra
 - E. Urethral
- III. Hematuria associated with extraurinary or para-urinary pathology
- IV. Essential hematuria

This classification is to be considered illustrative, not exhaustive, inasmuch as any and every disorder of the urinary tract, no matter what its anatomic location in that body system, may be productive of hematuria. This outline, however, does serve to point out the variety of causes of bleeding of the urinary organs, and the intensive and extensive survey which may be necessary to discover the etiologic factor of the hematuria. In addition to general medical investigation including hematologic studies, blood cultures and such, complete urologic survey comprising cystoscopy, retrograde pyelography, determination of separate renal function, bacteriologic smears and cultures of these separated urine specimens, and additional special tests may have to be done. With such a program of detection, the diagnosis will be established, and appropriate treatment can be instituted.

The broad classifications must be broken down further, and individual problems will be discussed under each heading. First there is the important situation of systemic diseases which may be productive of blood in the urine:

Table 2.—First Division of Classification

- I. Hematuria in general disease
 - A. Acute fevers
 1. Tonsillitis
 2. Scarlet fever
 3. Rheumatic fever
 - B. Chronic fevers
 1. Endocarditis (subacute bacterial endocarditis resulting in renal emboli)
 2. Malaria
 3. Brucellosis
 - C. Blood dyscrasias
 1. Leukemia
 2. Hemophilia
 3. The various purpuras
 4. Polycythemia
 - D. Deficiency and dietary disease
 1. Liver deficiency (hepatorenal syndrome)
 2. Scurvy
 - E. Circulatory stasis
 1. Cardiac decompensation
 - F. Diseases of unknown etiology
 1. Hodgkin's disease
 2. Hypertensive cardiovascular disease or arteriosclerosis with renal involvement
 3. Periarthritis nodosa
 4. Glomerulonephritis
 - G. Hematuria following administration of medication
 1. Sulfonamides
 2. Salicylates
 3. Barbiturates
 4. Anticoagulants (heparin, dicumarol)

It may be of interest to cite some cases in which bleeding of the urinary tract was of prominence in general systemic ailments:

Case 1.—Hematuria Due to Bacterial Endocarditis. A 22 year old white woman was admitted to the New York Post-Graduate Hospital because of sudden, total, gross hematuria without accompanying urinary symptoms.

There was a history of low grade fever during the preceding three weeks with chills and sweats.

Physical examination revealed pallor and a soft, systolic, apical cardiac murmur with no other pertinent findings. Temperature was 101 F.

Cystoscopy and retrograde pyelographic studies showed no abnormalities of the urinary tract; bacteriologic urinary studies gave negative results.

Two weeks following hospital admission, the character of the cardiac murmur changed, and at this time, too, arterial blood cultures were positive for *Streptococcus viridans*. Massive doses of penicillin were given, and the patient recovered fully.

In this case, a cardiac ailment was brought to treatment because of the renal manifestation of bleeding. Final diagnosis was, of course, subacute bacterial endocarditis with emboli to the kidneys producing hematuria.

Case 2.—Hematuria Due to Blood Dyscrasia. A 17 year old boy had been having various joint pains for several months. Subsequently, blood appeared in the urine in association with small hemorrhages into the skin.

Physical examination disclosed purpuric skin manifestations and a palpable spleen.

Blood studies showed an anemia with normal white and differential blood counts. The platelet count was low. Urinalysis showed innumerable red cells.

A diagnosis of idiopathic thrombocytopenic purpura was made. Nevertheless, because of the hematuria, urologic investigation, which resulted in negative findings, was performed to eliminate the possibility of a coexisting lesion of the urinary tract, though laboratory studies of the peripheral blood readily disclosed the cause of the bleeding from the urinary tract.

Splenectomy was performed with complete remission of the hemorrhagic manifestation including the hematuria.

It has long been realized that many medications which the physician prescribes are capable of producing hematuria. This fact has been brought into particular prominence by the use of sulfonamides within recent years, and, most recently, the introduction of anticoagulants as therapeutic aids has added other agents capable of causing hematuria. The following case is illustrative.

Case 3.—Hematuria Due to Drug Administration. A 68 year old man was hospitalized because of an acute coronary arterial occlusion; myocardial infarction had occurred two years previously. Because of the fear of formation of a mural thrombus and possible embolism, anticoagulant therapy was immediately begun with dicumarol. Daily prothrombin levels were taken, but despite this close observation, there suddenly developed gross and massive hematuria, without clot formation, on the fifth day after starting dicumarol; the prothrombin time (undiluted) was 56 seconds. Vitamin K was immediately given parenterally, together with a transfusion of 250 cc. of whole fresh blood. The dicumarol was stopped, and the hematuria ceased.

After recovery from the coronary thrombosis, intravenous urography and cystoscopy were done to rule out the presence of disease of the urinary tract. Fortunately, no lesion was found.

This case illustrates a danger which the physician may encounter in the course of therapy with any drug but, of course, more prominently with some. Hematuria may be due to the drug which is administered, but, nevertheless, investigation of the urinary tract should be made to rule out co-

existing pathologic changes in the urinary tract.

Comprising the next group for review are those diseases of the urinary tract which per se can produce hematuria.

Table 3.—Second Division of Classification

II. Hematuria due to intrinsic diseases of the urinary tract

A. Renal

1. Calculi or crystals
2. Tumor, benign or malignant, capsular, parenchymal or pelvic
3. Infection, acute or chronic, including tuberculosis
4. Anomalies, polycystic disease, horseshoe kidney
5. Trauma

B. Ureteral

1. Calculi
2. Infection
3. Stricture
4. Tumor, benign or malignant
5. Trauma

C. Vesical

1. Tumor
2. Calculus or foreign body
3. Infection including ulcer
4. Trauma

D. Bladder neck and urethral

1. Disease of prostate (hypertrophy, infection, cancer)
2. Infection of seminal vesicles
3. Stricture
4. Infection of urethra
5. Tumor
6. Instrumentation

This grouping includes the ailments which are the particular province of the urologist; the chart reveals how varied in type and location the lesions may be which can produce hematuria and that urologic study must be complete in order to localize and identify a pathologic lesion. In fact, it behooves the urologist to be aware of more than a single pathologic entity in the urinary tract as witness the following case:

Case 4.—Hematuria Due to Two Simultaneously Co-existing Lesions of the Urinary Tract. A 42 year old man who had been having intermittent gross painless hematuria of several months' duration suddenly experienced severe left renal colic. Intravenous urography disclosed a pea-sized calculus in the lower portion of the left ureter close to the bladder. Manipulation of the calculus was performed in the hospital and, at the time of cystoscopy, a quarter dollar-sized papilloma of the bladder was seen and destroyed by fulguration. The calculus was removed also. See figure 1.

The tumor, of course, was the lesion which had caused the long-standing hematuria. It should be pointed out that one might expect passage of blood clots in the presence of a tumor of the bladder, but there is no characteristic pattern for hematuria in urologic lesions.

Case 5.—Hematuria Due to Renal Neoplasm. Gross hematuria was noted by a 56 year old woman. There were no associated urinary or systemic symptoms. A mass, presumably the right kidney, was palpable in the right upper quadrant of the abdomen. Retrograde pyelographic study showed a deformed, distorted right renal pelvis with a mass pushing the kidney down. A diagnosis of renal neoplasm was made, and right nephrectomy was performed. The pathologic diagnosis was hypernephroid carcinoma of the kidney with no invasion of the renal vein. The patient made an uneventful recovery.

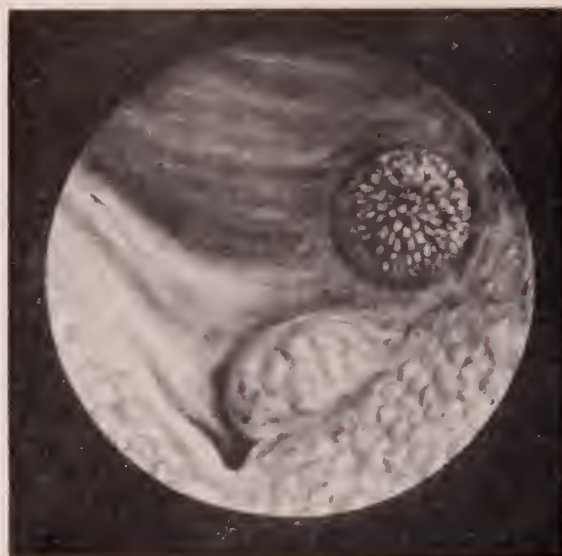


Fig. 1.—Illustration of papilloma of the bladder.

In this case, as mentioned, bleeding was the first sign of a renal tumor which, obviously, had been present for a great length of time before producing this single symptom. Had such a symptom been ignored, metastasis might have occurred shortly, and the patient might have been "inoperable."

Case 6.—Hematuria from Prostatic Varices and Recurrent Prostatic Hypertrophy. A 68 year old man had had transurethral resection of the prostate in 1942. Subsequently, he had been asymptomatic for six years when there suddenly developed grossly bloody urine with the passage of many clots. Cystoscopy was performed under spinal anesthesia and, after evacuation of clots, visualization of the bladder showed no abnormalities of that organ. Over the surface of an obviously intruding prostate gland there were, however, numerous dilated veins, rupture of which had accounted for the vesical hemorrhage. Transurethral resection of the obstructing prostatic tissue was performed, and the bleeding ceased.

The final diagnosis was bleeding from prostatic varices and recurrent prostatic hypertrophy.

It should be noted that gross hematuria is not at all infrequent with enlargement of the prostate; however, the possibility of an associated lesion, such as a tumor of the bladder, must be considered and ruled out by urologic investigation.

Case 7.—Hematuria Due to a Congenital Developmental Abnormality. An attorney, 30 years of age, who had been in good health all of his life, experienced a sudden, painless hematuria unaccompanied by any other symptoms. Physical examination was nonrevealing. Cystoscopy and pyelographic studies showed the presence of multiple cysts of both kidneys, with blood coming from the left kidney. A diagnosis of bilateral polycystic kidneys was made. The bleeding ceased spontaneously. Three years later, gross bleeding recurred, and the same findings were noted. On this occasion, because bleeding was prominent and profuse, a Rovsing operation was performed on the left kidney; many cysts were opened, the contents were evacuated, and pressure on the functioning renal tissue was reduced. There was no subsequent recurrence of

hematuria, and the patient has remained in good health. See figure 2.

Final diagnosis was urinary bleeding due to polycystic renal disease. It is of interest to note that the father of this patient died of "polycystic kidneys," no doubt because of hemorrhage. Some few years later, this patient's sister was nephrectomized by me for a grossly infected and destroyed polycystic kidney.



Fig. 2.—Retrograde pyelographic roentgenogram of polycystic kidneys.

There is another category of diseases which may be productive of hematuria; these are diseases outside of the urinary organs themselves, and due to the involvement of organs in close anatomic proximity to the urinary tract, urinary bleeding may be present.

Table 4.—Third Division of Classification

- III. Hematuria associated with extraurinary pathology
 - A. Acute appendicitis
 - B. Diverticulitis of the colon
 - C. Neoplasm of the colon, rectum or pelvic structures
 - D. Acute or chronic salpingitis

These are essentially self explanatory. See figure 3. It is easy to imagine an adenocarcinoma of the colon involving the bladder and causing bloody urine; in fact, it is my belief that in every case of malignant disease of the sigmoid colon or rectum there should be urologic investigation to rule out invasion of the bladder.

Another case in point is the following:

Case 8.—Hematuria Due to Appendicitis. A 33 year old man had pain in the right flank associated with low grade fever; tenderness was present in the flank, and

many red blood cells were found in a centrifuged urine specimen. Because of the latter, cystoscopic and retrograde pyelographic studies were made with negative findings. Later, a moderately inflamed appendix was removed from its retrocecal location where its tip had impinged against the ureter, thus producing the urinary symptoms and the microscopic hematuria.

By the same token, it must be pointed out that the appendix of numerous patients has been needlessly removed whereas the pathology rested in the urinary tract. Thus, symptoms and signs referable to the urinary tract must not be ignored, and urologic survey must perforce be performed in many cases when abdominal symptoms do not give a clearcut diagnosis.

In a fourth category called essential hematuria are placed those unusual and infrequent cases in which the cause of the bleeding defies detection even after exhaustive investigation. Eventually, after persistent and intensive search, final diagnosis is made and therapy carried out, but it is only the urologist's own limitations which fail at the earliest instances to discover the cause of the bleeding. Among these lesions are: varix of the renal papilla, a minute tuberculous renal ulceration, and papillary carcinoma of the renal pelvis. In the main, however, diagnoses can be readily made, and those cases which are disposed of with a diagnosis of essential hematuria are, fortunately, few and far between.



Fig. 3.—Cystogram showing large filling defect indicating carcinoma of the bladder.

It is obvious from the discussion that has been presented here and from the cases cited that from history and general physical examination the source of hematuria cannot be ascertained in the majority of cases. Only by a comprehensive urologic survey aided by laboratory procedures can an accurate diagnosis be established and the proper therapeutic program instituted.

The clinical significance of urinary bleeding cannot be overemphasized. When accurate diagnosis is delayed, the patient may often be deprived of opportunity for cure by either surgical or medical treatment, depending upon the nature of the lesion which is discovered.

Conclusion

Hematuria is per se neither a disease nor a clinical entity; it is merely a manifestation of an existing disease which demands complete investigation for the discovery of its etiology.

Hematuria may be accounted for by systemic disease, specific intrinsic diseases of the urinary tract, or diseases of organs in proximity to the urinary tract components.

The vast majority of cases of hematuria are due to purely urologic lesions; a high percentage of such cases is due to neoplastic disease of the urinary tract. Two or even more urologic lesions may coexist to produce hematuria, and so complete urologic study is essential.

A thoroughgoing medical and exhaustive urologic survey may be required to ferret out the etiologic agent of hematuria. Hematuria as a symptom must not be ignored, nor should investigation be delayed, for early diagnosis of the causative lesion is required to institute proper therapy and thereby secure a favorable prognosis.

77 Park Avenue.

Remarks on Surgery of the Sympathetic Nervous System

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Interest in surgery of the sympathetic nervous system was stimulated in 1923 when Royle¹ and Hunter² proposed lumbar sympathectomy for spastic paralysis of the lower extremities. In 1925, Adson and Brown³ proposed sympathectomy for Raynaud's disease. Since that time a large number of articles have appeared on surgical procedures for the relief of various vasospastic diseases. There are some diseases of the extremities which are primarily vasospastic in nature and which are ideally treated by sympathetic nerve surgery. There are other cases of vascular occlusive diseases which have an associated vasospastic element, and this latter may be relieved by blocking the sympathetic nervous system. It is my purpose in this discussion to remark on the disorders which have been most benefited by the operation and which are treated on a rational basis.

Raynaud's Disease

This is a true vasospastic disease which is described as coming under the functional vasomotor disturbances. It occurs chiefly in women, involving the upper extremities, but occasionally the lower extremities may be attacked later in the dis-

order. It may vary in degree, depending on the extent of the vasoconstriction of the vessels. The finger of the hand may become blanched like a sheet, a phenomenon which may be brought on from chilling as washing the hand in cold water. This white appearance may change in a few minutes to a bright redness or cyanosis. There may be considerable pain associated with the vasospasm. As a rule, the radial pulse can be palpated between the attacks, but during the seizure it is diminished. The ischemia of the fingers may lead to ulceration or gangrene.

This condition is most amenable to sympathetic block or surgery. As a diagnostic test one may inject novocain in the cervicodorsal sympathetic ganglia on the affected side, after which skin temperatures of the fingers are recorded, the thermocouple being used for this purpose. Increased warmth and dryness of the hand will be noticeable within fifteen or thirty minutes after the novocain block. If the response has been satisfactory, one may decide to give permanent relief by sympathetic ganglionectomy.

There are two operative procedures for denervating the sympathetics of the upper extremity.

The operation which removes the stellate ganglion, together with the second or third dorsal ganglia and the intervening trunk, removes postganglionic fibers and nerve cells. It was shown by White and Smithwick⁴ and others that the smooth muscles of the blood vessels after this type of sympathectomy are sensitized to epinephrine and are still capable of contraction due to this hormone. The other type of operation, devised by Smithwick,^{5a} is primarily resection of the preganglionic fibers of the upper extremities. This procedure consists in cutting across the sympathetic trunk below the third dorsal ganglion, also cutting the rami to the second and third dorsal ganglia and resecting the second and third thoracic roots proximal to the ganglion, thus severing the preganglionic fibers going along the anterior root. It is advisable to put silver clips on all severed trunks to prevent regeneration, at the same time offering a localization on the roentgenogram for demonstrating the extent of the operative procedure.

In Raynaud's disease of the lower extremity, a sympathectomy of the second to the fourth lumbar ganglia and intervening trunk is done, and this is a preganglionic nerve operation without sensitization of the vessels to epinephrine. A lumbar sympathectomy is done through an incision of the lateral abdominal wall near the flank, splitting the fibers of the muscles and extraperitoneally exposing the sympathetic chain on the anterolateral aspect of the vertebral bodies. If this procedure is necessary on both sides, the operation is performed in two stages about one week apart.

Buerger's Disease (Thromboangiitis Obliterans)

This disease comes under the class of obliterative vascular disorders. The etiology is not entirely clear, and the statement that it occurs only in patients of Russian-Jewish extraction has been disproved. Whether it is primarily an infectious disease with thrombosis of the vessels has not been entirely proved. It is aggravated by the vasoconstrictive action of nicotine in smoking. It occurs in men of the third and fourth decade and involves more frequently the lower extremities. The upper extremities may be involved as well, especially in the later stages of the disease. The first symptom of this disorder may be intermittent claudication. There is usually diminution in the pulsation of certain arteries, as the posterior tibial or dorsalis pedis. In the advanced stages, the pulse cannot be palpated. There may be changes in the color of the foot and toes. When the foot is lowered,

it changes color to a bluish red, and on elevation it becomes pale and white to normal. In the advanced states there is considerable pain of a permanent and continuous nature. Ulceration and gangrene may appear about the toes. While this is primarily a vascular obliterative disease, there is a variable amount of vasospasm, and its relief may improve the circulation to the extent that chronic ulcers may heal and a threatened gangrene is prevented.

Several diagnostic tests have been used to determine the degree of vasospasm. Fever therapy from intravenous typhoid vaccine is no longer used. Spinal anesthesia is sometimes used to block sympathetic and other nervous impulses, a measure which is just as effective as blocking the ganglia by direct novocain injection. The latter is usually preferred, and in either case the skin temperature can be taken as previously indicated.

To perform a sympathetic block in the lumbar region, four needles are used opposite the second to the fifth lumbar interspaces, introduced 4 cm. from the midline so as to inject the ganglia and chain on the anterolateral aspects of the bodies of the vertebrae. Novocain is first injected, and if a good response is obtained, a longer-acting anesthetic like bromsalizol or eucupine may be used. In some cases longer or permanent action may be obtained by using 95 per cent ethyl alcohol.

Arteriosclerotic and Diabetic Endarteritis

In older people with arteriosclerosis and circulatory impairment of the extremities, there may be a chronic ulcer, threatening gangrene or intermittent claudication. Although this is mostly an occlusive vascular disease, there frequently occurs an associated vasospasm which can be relieved by sympathetic block. The latter procedure can relieve the symptoms, heal the ulcer, and sometimes prevent gangrene. Although gangrene is evident, a sympathetic block may permit amputation at a lower level. The procedure of choice in older patients of poor risk would be novocain-alcohol blockage. If the patient is a good surgical risk, sympathectomy would be more effective and permanent. The chief objection to alcohol is the neuritis occurring in about one-half the cases, which may be troublesome to a neurotic patient.

In diabetic endarteritis there is a large vasospastic element, and some of the most dramatic results have followed sympathectomy and sympathetic blockage.

Acute and Chronic Thrombophlebitis

A greatly swollen and edematous extremity with pain is especially disabling. Ulcerations may occur which are slow to heal. In many of these cases there are associated varicose veins.

In acute thrombophlebitis, improvement may be obtained by novocain blockage. Ochsner and DeBakey⁸ advised novocain blockage at daily intervals if necessary. Following the novocain block, the extremity will be softer, less swollen and warmer than previously. In chronic disorders of this type, the blockage can be longer-lasting by using alcohol; or, if the patient is a good surgical risk, by a sympathectomy.

Acute Arterial Embolism or Thrombosis

In this condition there is always a large amount of vasospasm in the distal part of the vascular tree. It is not always an easy matter to remove the embolus or thrombus from the vessel surgically. It is beneficial in most cases to start sympathetic block early, which may be repeated every day for the first week or two.

Cerebral Vasospasm

Occasionally in a certain type of person, sometimes associated with arteriosclerosis in older patients, there occurs spasm of cerebral blood vessels manifested by sudden hemiplegia, hemianopsia, or sensory phenomena on the opposite side of the body of temporary duration. It may last fifteen to thirty minutes and clear up without residual symptoms. In these cases, it is undoubtedly due to spasm of the arterial system supplying these centers in the brain. If the spasm becomes recurrent or prolonged, the resulting cerebral ischemia may lead to permanent damage to the brain cells with permanent paralytic symptoms of the extremities. This condition is sometimes associated with migraine as well as other vascular disorders. It is not unusual in cases of migraine for the headache to be on one side and for temporary hemianopsia to occur, or numbness and paralysis of one or more extremities on the opposite side. These signs are of transient nature, but definitely represent a vasospasm of the cerebral vessels. If the patient could be seen with this disorder and novocain blockage of the cervicodorsal sympathetic ganglia could be done with immediate relief from symptoms, it would be diagnostic proof that the vasoconstriction is the etiology. This could be followed by cervicodorsal sympathetic ganglionec-

tomy, which should give the patient permanent relief and prevention of recurrence of these signs, possibly preventing permanent hemiplegia.

It is rather simple to block the cervicodorsal sympathetic ganglion with novocain by using a single needle inserted just above the middle of the clavicle, directed inward about 45 degrees until it reaches the head of the first rib or body of the seventh cervical vertebra. Here it is in contact with the stellate ganglion, and one may inject novocain after first aspirating to make sure the needle is not in a blood vessel or the pleural cavity. Within a few minutes there will develop a Horner's syndrome showing that the injection is effective. This is the injection technic for the blockage of the sympathetics to the upper extremities, head and neck. As described previously, permanent blockage may be obtained by sympathetic ganglionectomy.

Atypical Facial and Cranial Neuralgia

In addition to migraine, as mentioned before, there occur disorders of pain localized in the face and cranial region on one side which may have radiation into the neck or shoulder. These pains frequently are localized along the occipital or temporal arteries where there is great tenderness on palpation. Relief can be obtained by novocain blockage around the vessel during the attack or by blocking the cervicodorsal sympathetic ganglion. Occasionally one can give permanent relief by sympathetic ganglionectomy. The chief objection to this is the Horner's syndrome which gives a smaller pupil and a slight enophthalmos on the affected side. In bilateral sympathectomy, the change is on both sides and hardly noticeable.

Causalgia

This is a painful condition of the upper or lower extremity and frequently associated with injury of the peripheral nerve. It is sometimes described under major and minor causalgia, the latter being due to trauma of a trivial nature. Flothow and Swift⁷ described a traumatic sympathalgia in which there is a constant burning, painful condition of the distal part, with a shiny red skin and increased sweating. Roentgen examination may show osteoporosis of the bone. If the nerve trunk is involved in a scar, it should be attacked by the operation of neurolysis. In some cases of minor causalgia this is the procedure of choice. In the cases of minor causalgia, especially when an insurance company is involved, it is a particularly

disturbing disorder, and complete relief is difficult to obtain from any procedure as mentioned. When insurance is involved, it is best to use novocain blockage for a time before sympathetic ganglionectomy is performed.

Painful Amputation Stump

This painful disorder sometimes can be relieved by resecting the neuromas in the amputated stump. In most cases the disorder is more central, and surgical procedures on the pain pathways in the cord, as chordotomy, may be needed. In a few cases, resection of the sensory cortex in the brain will be necessary to remove the central impressions of the ghost extremity. In some cases, however, sympathetic blockage gives relief. If repeated novocain blockage eases the pain, permanent relief may be expected from sympathectomy.

Angina Pectoris

Some of the earliest work on the sympathetic nervous system was directed toward the relief of the angiospasm associated with angina pectoris. The efferent fibers which supply this reflex arc are chiefly from the superior cervical ganglion, while the afferent fibers are through the second to the fifth thoracic sympathetic ganglia. The angiospasm may be relieved by blocking the nerve impulse on either the efferent or afferent side. Superior cervical sympathectomy has been done with relief of the anginal pain. White and Smithwick⁴ and others advocate blocking the second through the fifth dorsal ganglia on the affected side. This blockage may be obtained with novocain and alcohol if the patient is not a good surgical risk.

Postherpetic Neuralgia

In acute and chronic pain of herpes zoster, the best relief is obtained by sympathetic blockage with novocain, and by sympathectomy in selected cases when it is chronic.

Carotid Sinus Syndrome

This condition is largely a reflex mechanism through the sympathetic nervous system in the region of the bifurcation of the carotid artery. Slight massage over this region may bring out the disorder manifested by fainting or a convulsion, extreme slowing of the pulse rate, and sometimes a severe drop in blood pressure. As a diagnostic test, novocain may be infiltrated in the region of the carotid bifurcation, when massage of the involved area will no longer bring on the attack. To give permanent relief the carotid artery may be

denervated by periarterial sympathectomy for a distance of 2 cm. above and below the bifurcation.

Scleroderma

In the early stages in young persons this disease may be benefited by sympathectomy. It is sometimes associated with Raynaud's disease. In the advanced stages, however, little result may be obtained from the procedure.

Essential Hypertension

Sympathetic surgery offers a new hope and relief to the large class of poorly understood patients with high blood pressure. It is most amenable to treatment in the young person with vascular hypertension without severe damage of the kidneys, blood vessels and heart. It is seldom that thoracolumbar sympathectomy is advised in persons over 50 years of age because of arteriosclerosis, which might prevent sufficient dilatation of the vascular system to give adequate lowering of the blood pressure. The selection of patients is most essential, and it is best that the patient be studied by an internist. To determine the suitability for the operation, the changes in blood pressure should be observed under the administration of sodium amytal, the cold pressor test, and sometimes splanchnic sympathetic novocain blockage. It is important to know the operative risk, and an electrocardiogram may be needed to determine cardiac damage.

It has been shown by Smithwick^{5b} that to get the maximum desired effect, it is necessary to remove the sympathetic ganglia and chain from the ninth dorsal to the second lumbar ganglia inclusive. The Smithwick procedure requires⁶ resection of part of the eleventh and twelfth ribs to gain access to the thoracic cavity and remove the ninth to the twelfth thoracic ganglia, and the greater and lesser splanchnic nerves; then the upper two lumbar ganglia are removed through an opening in the diaphragm. In men, it is best to preserve the second lumbar ganglion on one side. Recently, it has been my practice to use a modification of this procedure by resecting a part of the ninth and eleventh ribs, which enables one to resect as high as the sixth or seventh thoracic ganglion through the twelfth, thereby affording a more complete denervation of the splanchnic area; through the lower limb of the incision an opening is made below the diaphragm to remove the upper two or three lumbar ganglia. Sometimes silver clips are put on the divided nerves to prevent regenera-

tion and these may be demonstrated on the roentgenogram to show the extent of the operation. The operation is done in two stages, ten days apart. The Adson operation is a subdiaphragmatic procedure which includes resection of the greater and lesser splanchnic nerves and the upper lumbar ganglia with inspection of the adrenal gland. The Peet procedure is a supradiaphragmatic one and removes the greater and lesser splanchnic nerves with the lower thoracic ganglia. Favorable results are reported from these operations. The type of operation to be preferred in essential hypertension is the one that will give the most extensive sympathetic denervation to the splanchnic area and the lower extremities, at the same time affording access to the kidney area to rule out a tumor of the suprarenal body.

Conclusions

Sympathetic block is indicated in most of the vascular occlusive diseases of the extremities in which there is a variable amount of vasospasm. This can be relieved with improvement of the circulation so that healing of a chronic ulcer occurs, or a threatened gangrene may be prevented.

This measure is most helpful in acute thrombophlebitis of the lower extremity, especially after the use of local anesthesia of short duration. In the chronic forms with considerable edema an anesthetic of longer duration should be employed, or

a permanent sympathectomy should be done.

Many painful conditions of poorly understood etiology and mechanism may be relieved by sympathectomy or novocain blockage. Some of these mentioned are causalgia, postherpetic neuralgia, painful amputation stump, and atypical facial and cranial neuralgia. This therapy is helpful in relieving the pain of angina pectoris and the pain associated with various vasospastic diseases in the body.

Sympathectomy offers a new hope in the early case of essential hypertension. This type of operation done for this condition is the one which gives adequate sympathetic denervation of the splanchnic area, kidneys and lower extremities.

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**The Scientific Department of The Journal
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On Data of Notable Interest**

The General Practitioner Today

R. B. ROBINS, M.D.

CAMDEN, ARK.

Mr. President, Fellow Members of the American Academy of General Practice, and Guests:

It is indeed a pleasure for me to bring you official greetings from the officers and directors of the American Academy of General Practice. I was complimented and delighted when I was selected to represent this national organization at your meeting here today.

Last June a year ago (1947) I was in Atlantic City at the centennial meeting of the American Medical Association. While there I attended the caucus where we organized the American Academy of General Practice. It has been phenomenal how this organization has grown since that date. At the present time charters have been issued in thirty-two states; there are, in other words, thirty-two state chapters. The chances are that by the time of our national meeting in Cincinnati March 7, 8 and 9, we will have chapters in all forty-eight states, the District of Columbia and Hawaii. The present total membership is around 7,000, and we will be crowding 10,000 by the time of our March meeting. A year hence we should have 20,000 members. I feel sure that this organization is destined to be the second outstanding medical organization in this country—second only to the American Medical Association. Most of the doctors in this country are general practitioners and they have been an unorganized group, as you know. The specialists have ruled the roost in organization.

Preliminary plans are being made to publish a journal. In due time we hope to have one designed especially for the general practitioner.

Our headquarters has been established in the middle of the United States, at Kansas City, with a headquarters staff of ten people, which will probably be doubled within a year. Our staff is headed by one of the country's most capable lay executive secretaries, Mac Cahal, a graduate attorney experienced in medical secretarial work, having the last few years been the efficient secretary of the American College of Radiology in Chicago.

Our organization is not an antispecialist group

by any means, but it seeks to emphasize that the family doctor is the foundation stone in American medical practice. Our relations with the various specialty organizations and the American Medical Association are most cordial.

A number of factors have stimulated the family doctor to organize. One in particular has been the tendency of hospitals in certain sections to restrict admissions to patients of diplomates or specialists. Why should the family doctor be asked to abandon his patient at the hospital door? In 85 per cent of the cases the competent general practitioner can give as good service as any specialist, and in the other 15 per cent the family doctor is able to judge the need for a specialist and the particular specialist needed.

An outstanding objective of this organization will be the promotion and development of postgraduate training for the general practitioner. In order to hold his membership in this organization he will have to do at least 150 hours of postgraduate work every three years. I should like to direct your particular attention to this requirement, which is quite different from that of other organizations. I will use as an example the American College of Surgeons. Once you become a member, you are always a member regardless of whether you keep up with progress or not.

There are a number of trends that should concern us in the medical profession today. One of them is the tendency on the part of hospitals here and there to invade the practice of medicine by using employed physicians. There are certain people in the hospital world who think that hospitals should take over the practice of medicine by employing full time salaried physicians with the hospital collecting the fees for services rendered. We should be on the alert and fight this tendency wherever we find it. Hospitals exist for the benefit of the patient and the physician. The hospital is the physician's workshop. It was not intended that the physician should be the economic servant of the hospital.

The family physician or general practitioner is the backbone of medicine in this country, and we must look forward to the development of more physicians of this type and to the improvement of

Address delivered before the Florida Chapter of the American Academy of General Practice, Miami, Oct. 24, 1948.

Speaker, Congress of Delegates, American Academy of General Practice; Democratic National Committeeman for Arkansas; Professor of Medical Economics, University of Arkansas School of Medicine.

those who are already in this field of medicine. That is the real objective of this organization which you and I are representing here today. The tendency to overspecialization has been one great factor responsible for the movement in certain quarters for the socialization of medicine by government.

To summarize up to this point:

1. We must encourage more medical students to plan to enter general practice.
2. We should encourage our medical schools to adapt their teaching program to the training of physicians for general practice.
3. We must see that hospitals do not discriminate against general practitioners.
4. We must provide more postgraduate training for the man in general practice.
5. We must teach the public that the competent general practitioner can handle 85 per cent of their illnesses. A broader recognition of this fact will reduce the cost of medical care for the people and reduce the urge for socialization of medicine.

I did not come here to appear in a double role and I am fully aware that the election is only a few days away. It happens that I am Democratic National Committeeman for the State of Arkansas, having been elected for my second term at the August primary, and I happen to be the only doctor on the Democratic National Committee.

I began to take interest in political affairs a number of years ago, and it is my firm belief that more doctors should concern themselves with political affairs. Democracy functions through politics, as you well know. It is inconsistent of us to criticize actions of politicians while we ourselves evade political service or interest in political affairs.

Doctors have a tremendous political potential with their patients and friends, but it is seldom used. It is too generally regarded that political activity is a dirty game and beneath the dignity of a professional man. When we find politics dirty, it is so just because of this attitude on the part of self-respecting people. They permit it; otherwise it would not be so.

The immediate past president of the American Medical Association, Dr. Edward Bortz, has appealed to doctors to take up the duties of statesmen. The traits of patience, understanding and perseverance that are to be found almost always in a successful doctor are likewise needed in politicians and statesmen. Too often they are lacking. Dr. Bortz is eminently correct in his admonition to physicians.

In former years we had more doctors in public life than we have today. Six doctors signed the Declaration of Independence, and three signed the Constitution of the United States. Sun Yat Sen, the first president of China, was a physician. General Leonard Wood, a great military leader, was a physician, as was Clemenceau, who led the French nation through the first World War. William Henry Harrison, one of our presidents, was at one time a student of medicine. The Secretary of Interior in President Hoover's cabinet was Dr. Ray Lyman Wilbur, who was president of the American Medical Association in 1923. The Secretary of Interior under President Coolidge was Dr. Hubert Work, who was another president of the American Medical Association (1921).

The roster of medical men who have been distinguished in the political life of this and other countries would include many of the great names of history. Doctors probably do not take as active a part in political affairs today as formerly because of the fact that medicine is a more exacting and time-consuming task than in other years. There are at the present time seven doctors and two dentists in the House of Representatives and none in the Senate.

I want to take time at this moment to pay tribute to one of our contemporary doctors who holds a distinguished place in the field of politics and statesmanship. I refer to Congressman Walter H. Judd, who some time back (Minnesota Medicine, 1943) said: "I am convinced that what we need most in Washington is more doctors in government and, above all, more of the kind of mental habits that good doctors must have."

Doctors have tremendous obligations as citizens. They need to take part in helping a sick society to recover and in the creation of a more stable society. Physicians are as capable of knowing human needs and of understanding human relations as any other group in our society. It behooves our medical men to be good citizens as well as good doctors. Interest in public affairs is a major responsibility of the medical profession today since there is so much at stake.

I have opposed Mr. Truman's socialized medicine program from the beginning and will continue to oppose it. I am happy to state that there is not a Congressman nor a Senator in my state who favors this program. It is my understanding that that is not quite true in Florida. There are present in America today two schools of thought. The result of the conflict between these ideas will de-

termine whether we shall have capitalism with a free market economy, allowing each individual to work and earn his own degree of security, or whether we shall have socialism with security handed down by a paternalistic state in exchange for individual freedom. I am always reminded of the thought that you can have security in a jail, but you cannot have freedom.

My friends, I am not ready to impose the theories of Karl Marx upon the people of America. There are some ambitious Caesars within our own government who want socialized medicine, who would impose the theories of totalitarian Europe upon us, because they think it will advance their political fortunes. They think it is good political bait for the voter.

We hear much about bureaucrats. Someone has said that a bureaucrat is a Democrat who has a job that a Republican wants. The latest bureaucrat story making the rounds in Washington concerns an "efficiency expert" who stalked into one of the large offices and walked up to two clerks. He asked one of the clerks, "What do you do here?" The clerk, fed up with red tape, buck-passing, forms, and above all, "efficiency experts," answered, "I don't do anything!" The efficiency expert nodded, made a note, and then asked the second clerk, "And you, what's your job here?" The second clerk, a fellow sufferer, replied, "I don't do a thing, either." The efficiency expert's ears perked up, "Hmmmmm," he said, "duplication!"

On September 2, Mr. Oscar Ewing, Federal Security Administrator, released his 186-page report to the President. The key recommendation is for Compulsory Federal Health Insurance. Jack Ewing was Vice Chairman of the Democratic National Committee when I went on the committee. As you remember, Mr. Truman made him Federal Security Administrator. When he went into this office, I asked him how he felt regarding the Wagner-Murray-Dingell Bill — Compulsory Federal Health Insurance—and he told me that his mind was open, that he had no convictions, but that I should understand that as an employee of Mr. Truman's he would have to be guided by the wishes of the boss. Not long ago I talked to him at Cleveland and, in the conversation, he talked of his hope that the Congress would establish a new cabinet post to be in charge of health, security and education. I could see that he had ambitions to hold this cabinet position. I asked him if he would appoint a doctor to head the health subdivision of the department, and he indicated that he

would not. He told me that doctors were not executives.

Compulsory Health Insurance is Political Medicine. It is a politician's strategy whereby people are tricked into accepting a new tax in return for a promise of health services. Do not forget, my friends, that Lenin said: "Socialized Medicine is the keystone to the arch of the Socialist State."

Bismarck of Germany invented Compulsory Health Insurance so that he could place the workers under obligation to him and make them subservient to his government. This was a great source of strength to Adolph Hitler in his ruthless rise to power. The English have fallen for it, as you know, and the morale of physicians, dentists and nurses over there today is being undermined. Hospitals are overcrowded with malingerers. Really sick people find it difficult to obtain adequate medical care.

A few days ago in England, Sir Richard Gregory suggested that it may soon be necessary to fill out a form and get permission before becoming a parent in England. He said local medical officers soon may get letters saying: "Dear Sir: I wish to become a mother. Please tell me what to do about it and send the necessary form of application for my signature."

Gentlemen, in our efforts to establish voluntary health insurance plans in our country we must also guard against some faults that may arise. I should like briefly to direct your attention to a list of ten commandments concerning voluntary health insurance which were written by my good friend, Tom Hendricks, Secretary of The Council on Medical Service of the American Medical Association:

1. Thou shalt not allow the quality of medical service to the individual American ever to deteriorate behind the curtain of prepayment.
2. Thou shalt not take a fee for service from the prepayment plan fund and then add an extra extreme bill thereto to the patient merely because you can get away with it.
3. Thou shalt not disparage the voluntary prepayment system, for American medicine is committed to this method of easing the financial burden of sickness.
4. Thou shalt not oversell prepayment. It is only one of the several elements available to assist the individuals in the pursuit of health, and is only one answer to the federal control of medicine. There are many others as can be seen from the ten point national health program of the A. M. A.

5. Thou shalt not damn prepayment with faint praise.

6. Thou shalt readily admit some imperfections in prepayment. At the same time thou shalt indicate that the voluntary and experimental nature of prepayment plans constitute a great measure of their strength.

7. Thou shalt do everything possible to help maintain actuarially correct data and as a participating physician thou shalt willingly provide necessary information which will enable prepayment plans to keep necessary records.

8. Thou shalt abide by the decisions of the majority in your society and publicly support the prepayment plan adopted and do your utmost to make it work.

9. Thou shalt not, however, become a prepayment "cultist," stating that one particular type of voluntary prepayment system is the only correct method and that all other approaches are wrong.

10. Thou shalt continue as an American physician to stress the dignity of the individual and the fact that one's health is much more the concern of the individual than it is the concern of any political unit of society and shall continue to urge all individuals to assume their proper share of this responsibility.

Let us wake up, my friends, and preserve in this nation our private practice system of medical care—our American way of life.

Acute Anterior Poliomyelitis: Case Report with Comments on Therapy

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AND

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Aware of the dangers of conclusions based on the analysis of 1 case, we were prompted to report this case and its apparent response to the therapy given because of its remarkable correlation with some ideas presented in the experimental literature.

This case was one of severe ascending acute poliomyelitis with complete recovery but temporary alarming paralyses. The therapy was directed at stimulation of vital centers of the brain stem by stimulants that improve the capillary tonus. For this purpose coramine and vitamin C were chosen on a physiologic basis.¹ At the time that the therapy was given, we were not aware of the striking implications which we now wish to discuss in the hope that others may try the drugs in series of cases for critical evaluation.

Report of Case

A. S., a robust, blonde, white boy aged 7, was admitted to the Jackson Memorial Hospital on May 27, 1944 at 11:00 a.m., acutely ill and very restless. Physical examination revealed positive Kernig and Brudzinski signs. The patient was incontinent with a temperature of 101.4 F. Reflexes were hyperactive all around. A lumbar puncture at this time revealed a slight reaction to the Pandy test, cell count 30 with 29 mononuclears, sugar 62 mg. and protein 44 mg. per hundred cubic centimeters, and colloidal

gold curve zero. The red blood cell count was 4.5 million and the white blood cell count 5,900. Urinalysis gave negative results.

During the next twenty-four hours the patient remained very restless, became stuporous and there developed inability to swallow. One thousand cubic centimeters of 10 per cent glucose in saline was given as were atropine for sialorrhea and sulfadiazine by medicine dropper. Regular treatment with insulin, 10 units per day, was started.

Pronounced cyanosis and a weak, thready, irregular, slow pulse developed thirty-seven hours after admission. The respirations became very shallow and rapid. Coramine, $\frac{1}{4}$ ampule, was given every thirty minutes as needed to keep the pulse regular. After about three hours the patient could be maintained on this dosage of coramine given each hour. Oxygen was given by nasal catheter, and an occasional dose of luminal sodium was given for extreme restlessness. The temperature at this time was 102 F., and the pulse rate was 80 to 92 when it could be measured. Four hours after this midnight crisis, the patient fell asleep with a regular pulse but still shallow respirations. The inability to swallow lasted thirty-six hours after the crisis.

From the forty-first hour after admission to the ninety-sixth hour, the course remained stormy with extreme restlessness, rapid but bounding pulse, inability to raise the head or move the arms or swallow, and pronounced sialorrhea. The pulse rate recorded was between 110 and 120, while the temperature slowly fell to 100.6 F. The coramine and atropine were continued, the sulfa drug discontinued, and cevalin, 100 mg. each day, was added to the intravenous fluids. The nurse at one hour took it upon herself to omit the coramine because of "overstimulation," at which time the pulse became immediately shallow and irregular. This omission was rectified at the next hour. Urticaria developed, but cleared when the sulfa drug was discontinued.

From this time to the day of discharge from the hospital, the course was one of progressive recovery. On

the fifth hospital day there developed a severe headache and speech defect during the night. The patient occasionally vomited, but took semisolid foods at about the one hundredth hour and arrived at good contact with the outside world on the fifth day. Temperature, pulse and respirations became normal on the fifth day, at which time the coramine was stopped and multicebrin added to the therapy. He could not raise his head until the seventh hospital day. On this same day he complained of backache and inability to extend his legs without pain as well as pain in the lower extremities on passive motion. He was discharged from the hospital on the eighteenth day without residuals.

He remains well at this time without evidence of having had poliomyelitis, except for a slight subjective weakness of the left arm.

Discussion

In recent years many types of therapy have been used for the treatment of Heine-Medin disease, empirically and sometimes symptomatically, experimentally and on humans. The trials of physical therapy based on symptomatic and electromyographic studies have been most prominent. Gurewitsch and O'Neill² recommended hot baths in preference to the much used Kenny method of therapy. Watkins and Brazier,³ in a critical analysis of cases treated with prostigmine, Kenny packs and luminous heat, came to the conclusion based on electromyographic observations of muscle activity during "spasm" that dry heat yielded best relief from the "spasm." The whole problem of "spasm" was, however, opened by Pollock and others,⁴ who questioned its significance, and, indeed, its presence at all.

In recent trials of chemical agents, most drugs have been shown to be of questionable or negative value. Watkins and Brazier³ indicated that prostigmine does not alter the ever present muscle stretch potentials of polio. Ransohoff⁵ claimed that in 21 of 29 cases there was recovery following curare treatment. Curare, it was concluded, abolished abnormal stretch reflexes, as shown by electromyographic studies. Richards, Elkins and Corbin,⁶ however, presented 18 cases in which the course of the disease was unaltered by curare. Charbonneau⁷ claimed remission of paralysis by the use of iodobenzomethylate hexamethylene-tetramine and sodium salicylate. Galsemium was tried by Holman.⁸

In the experimental field many correlations have been studied, for the most part concerned with metabolic and nutritional factors. Lichstein, McCall, Elvehjem and Clark⁹ reported the influence of folic acid deficiency in the monkey. Holtman¹⁰ indicated that thiouracil, a basal metabolic rate depressant, shortens the incubation period of polio virus inoculated in the rat, and that cold temperatures, which increase the basal metabolic rate,

protect the rat from the virus. Curley and Aycok¹¹ reported the effect of stilbestrol on resistance to experimentally produced polio. He concluded that the estrogen enhances the resistance to polio virus in body tissues other than brain tissue, but not in the latter. Waisman, Lichstein, Elvehjem and Clark¹² and Rasmussen, Waisman, Elvehjem and Clark¹³ in work with fat and pyruvate on the thiamine deficient mouse, a state already proved to protect against polio, showed that a state of thiamine deficiency causes a polyneuritis which has then the ability to protect the animal from the polio virus. High fat diets use little thiamine; and in animals deficient in thiamine but on a high fat diet polyneuritis does not develop, and consequently there is little protection from the virus. Pyruvate, a product increased in the body in thiamine deficiency, offers some protection from polio.

Coupled with these astounding experiments, the facts obtained from the work of Howe and Bodian,^{14a,b} who indicated that neurons in a late stage of chromatolysis are protected from inoculations of polio in the monkey and who presented an animal diseased with tuberculosis and dietary deficiency similarly protected, lead to the astounding conclusion that follows.

Diseased neurons and those neurons that show late simple chromatolysis are resistant to the ravages of poliomyelitis. A simple increase in the basal metabolism may also serve to protect animals to some degree from the polio virus.

In this 1 case, there is, of course, doubt of the true value of therapy. We know that restlessness in itself casts a more favorable prognosis than the state in which the patient "sleeps the night through to awaken paralyzed." Bodian and Howe¹⁵ indicated that severe pathologic changes may occur in relatively silent areas of the brain and cord, producing few manifest symptoms. We wish, however, to present our conclusion in the hope that it may be used again.

It is our belief that the coramine used may have acted as an overstimulant to vital centers of the brain stem, and coupled with the vitamin C gave relief from the edema that accompanies the most severely diseased neurons.¹⁶

The clinical course followed the Type II of Draper,¹⁷ namely, insidious onset ascending to the central nervous system. The first symptom was incontinence, while late in the course a speech defect was noted. This latter lesion was shown pathologically first by Thomas and Lhermitte.¹⁸

Summary

A case of ascending poliomyelitis of a bulbar type is presented in which the patient recovered without residual paralyses on a continuous regime of coramine and vitamin C. No definite conclusions can be made on the analysis of 1 case.

New therapy for polio and the therapy used in this case are discussed with the conclusion that our treatment caused an increase in metabolism which may have served to protect neurons from the polio virus.

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426 Ingraham Building.

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2:30 p.m.

Quincy, Monday, Oct. 24, 1949

Palatka, Wednesday, Oct. 26, 1949

Sebring, Thursday, Oct. 27, 1949

Ft. Lauderdale, Friday, Oct. 28, 1949

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More About Naturopaths and Naturopathy

Members of the Florida Medical Association as a whole probably do not appreciate the vigorous fight which the President of the State Board of Health, the State Health Officer, the Director of the State Bureau of Narcotics and the Chairman of the Legislation and Public Policy Committee of the Association have been waging to protect the public from practitioners of naturopathy.

In the March 1948 issue of The Journal an editorial pointed out that naturopaths have been carrying on a colossal bluff and pretense, that they have been inadequately trained, that they have changed the definitions of their "scientific terms" and even their aims to suit the purpose of the hour, and that the very nature of their training makes them unqualified to prescribe potent drugs. Despite these facts there are powerful lobbyists in the Florida legislature who are attempting to perpetuate their hypocrisy, and there is an ever dwindling but still effectual number of influential people who are championing their ignoble activities.

Early during the last session of the legislature a bill designed to abolish the practice of naturopathy in Florida was introduced by Senator Philip D. Beall, Jr., of Pensacola and was referred to the Public Health Committee of the Senate for hearings. On April 19, the State Health Officer, Dr. Wilson T. Sowder, appeared before the committee, testified at length and presented a most impressive array of facts and evidence damning to naturopathy. One William J. Faulkner gave testimony which showed that he had received a license to practice naturopathy in Tennessee after a fourteen day course. The Director of the State

Bureau of Narcotics, Mr. M. H. Doss, testified that a naturopath known to him had been granted a license to practice after not more than two and one-half months of schooling. A representative of the Federal Bureau of Narcotics, Mr. T. W. McGeever, also testified that Florida is the only state in the Union which permits naturopaths to prescribe narcotic drugs. There was further impressive testimony, but the bill was killed in the committee by a vote of 7 to 2. Those voting for the bill were Senators William A. Shands of Gainesville and T. LeRoy Collins of Tallahassee, while those voting against it were Senators J. Edwin Baker of Umatilla, John R. Beacham of West Palm Beach, J. C. Getzen, Jr., of Bushnell, Charley Eugene Johns of Starke, Alexander G. McArthur of Fernandina, G. Warren Sanchez of Live Oak and Raymond Sheldon of Tampa.

Not long afterward, Senator Beall presented another bill to the legislature which would have forbidden naturopaths to prescribe or administer narcotic or hypnotic drugs and would have prevented them from treating cancer and communicable and venereal diseases. After hearings, this bill was voted upon unfavorably, 5 to 4. Those voting for the bill were Senators Shands, Collins, Beacham and Sheldon. Those opposed were Senators Baker, Getzen, Johns, McArthur and Sanchez.

About the same time, Representative T. C. Merchant, Jr., of Madison introduced a similar bill in the House of Representatives which, after extended hearings, was reported favorably in the Public Health Committee of the House by a vote

of 13 to 4. Those voting for the bill were Representatives F. W. Bedenbaugh of Lake City, O. L. Burton of Eau Gallie, Grady W. Courtney of Millville, John W. Henderson of Tallahassee, R. M. Merritt of Pensacola, Wankard Pooser of Marianna, D. H. Saunders of Ft. Pierce, Norwood B. Strayhorn of Ft. Myers, James H. Sweeney, Jr., of DeLand, James H. Wise of Crestview, Alexander MacWilliam of Vero Beach, and Merchant. Voting against it were Representatives Mabry A. Carlton of Jacksonville, George C. Dayton of Dade City, Gus J. Dekle of Perry, and Leonard A. McKendree of Fernandina. Prominent among those who attempted to bring the bill to a vote in the House were Representatives Sweeney and Woodrow M. Melvin of Milton. The bill, however, along with other good bills, died in the House because of the rush and stampede toward the end of the session. It has been reported that there were a few legislators who worked to prevent the bill from reaching a vote in the House.

On March 30 of this year, Mr. Harry S. Avery of Nashville, Tenn., who had been employed by a committee appointed by the Governor of Tennessee to investigate licensing and practice of naturopathy in that state, wrote a long, explicit letter to Dr. Sowder giving the benefit of his observations and experiences during the successful fight waged in Tennessee to cast out naturopaths. Toward the end of his letter Mr. Avery wrote:

... It is my considered opinion that we would not have been successful in Tennessee in persuading the Legislature to abolish this so-called healing art of naturopathy ... [unless we had] exposed rather generally from one end of the State to the other the quackery and fakes they were perpetrating upon their patients. I think it would have been quite impossible to have persuaded our Legislature to take the action it did by simply relying upon generalities and advices from the medical profession.

I am quite sure from what I know of the situation that the naturopaths are certainly well entrenched in your State [Florida]. They realize ... [their] precarious situation ... therefore they will not hesitate to expend most of their assets if need be to prevent adverse legislation. ...

Testifying before the Public Health Committee of the Senate, Dr. Sowder stated:

According to the view of my Board, and of our Governor it is proper for the State Board of Health to investigate and to give its views on any matter that affects the health of the people of this state. ...

I am not here today as a medical doctor nor as a representative of the medical profession but as the Health Officer of Florida in behalf of all the people of Florida to entreat you to investigate a matter which only the legislature can correct. ... I do not come as a partisan for the Florida Medical Association although I have done my best to interest its members in this problem for several years but with only indifferent success. Many years of experience have led the organized medical profession to feel that organized effort in this direction is sure to be ascribed to selfish motives. There is, however, much interest [being shown by members of] the medical profession, but not more than by the lay public. ...

It seems high time that members of the medical profession show considerably more interest than they have in the past. Most Doctors of Medicine today have larger practices than they would wish; hence they cannot justly be accused of selfish motives and further aggrandizement of their practices by outlawing naturopathy. The issue is clear, and the principle is high. Naturopaths simply are not qualified to prescribe or administer potent drugs. If they are allowed to do so, it follows that the health, safety and even the very lives of the public are endangered thereby.

The Journal extends a word of hearty thanks and appreciation to those leaders who have been carrying on the worthy fight and also ventures to suggest to the opposing legislators that in the future they investigate more carefully before they put themselves in the public record by supporting a sham. It likewise wishes to reiterate a statement made in March 1948: "We believe that the Florida state legislators will hold the same view as did those of Tennessee. We believe they . . . will prohibit the practice of naturopathy in this state." The prevention of unqualified persons from prescribing and administering potent drugs and from treating patients with serious diseases should be our next aim.

A Contribution to the History of Medicine in Florida

It is with pleasure and with pride that The Journal congratulates the Assistant Editor, Dr. Webster Merritt, on the publication of his book, "A Century of Medicine in Jacksonville and Duval County." Coming off the University of Florida Press early last month, this valuable contribution to the annals of Florida medicine and Florida history marks the successful completion of a monumental undertaking. In its pages live again the dominant figures, events and movements that shaped the medical history of the area from the arrival of the first physician in the closing years of the eighteenth century on across the entire span of the eventful nineteenth century. Graphically portrayed are the poignant drama of the terrifying epidemics, strange maladies and weird superstitions of the period. Through twenty carefully documented chapters, the fascinating narrative of the tribulations and triumphs of the courageous pioneers who laid the foundation for sound

medical practice in Florida unfolds in appropriate crescendo commensurate with the changing times and the development of the region. Included is the early history of the Florida Medical Association and of the Florida State Board of Health.

From boyhood, Dr. Merritt has cherished deep interest in the history of his native state. His interpretations of that history are familiar to readers of the *Florida Historical Quarterly*, and also in particular to readers of *The Journal* through the series of articles on medical history which have appeared from time to time in its columns. He is a former president of the Jacksonville Historical Society and for several years has been vice president of the Florida Historical Society. He has also made notable contributions to medical literature of a scientific nature.

The task of the author in assembling the material for this volume was truly prodigious for it involved gleaning from collections, keepsakes, photographs and clippings of the older generations the obscure record that survived Jacksonville's disastrous fire of 1901. With the gift of the true historian, he has sifted fact from rumor and fable and has preserved for posterity an authentic and absorbing account, profusely illustrated with rare old photographs and drawings, which is of interest alike to his colleagues of the medical profession, the members of allied professions, lay readers and historians.

It is peculiarly fitting that this highly valuable contribution to the history of Florida should come from the University of Florida Press. Born in Gainesville, Dr. Merritt is a distinguished alumnus of the University of Florida. He was its first Groover-Stewart scholar in the College of Pharmacy and recipient of the D. W. Ramsaur Gold Medal for highest averages in all studies; he is an alumni member of the Beta (Florida) Chapter of Phi Beta Kappa. After completing his medical education at The Johns Hopkins University School of Medicine and serving as house officer on the Harvard Medical Service of the Boston City Hospital, he returned to Florida in 1936 and has since that time practiced in Jacksonville.

In felicitating Dr. Merritt on the occasion of the publication of his book, *The Journal* expresses the hope that this busy internist and editor will find time to continue his historical pursuits.

Shaler Richardson

Dr. Elmer Lee Henderson President-Elect of the A. M. A.

Unanimously elected by the House of Delegates of the American Medical Association at its Atlantic City Session in June, Dr. Elmer Lee Henderson of Louisville, Ky., becomes President-Elect and will automatically accede to the presidency next June in San Francisco. Kentucky born, Kentucky bred and Kentucky educated, this distinguished Southern surgeon will take over the helm of the world's most powerful medical organization at an opportune time to become a key figure in medicine's showdown with proponents of government compulsory sickness insurance, which is sure to be an important issue in the 1950 Congressional elections. Described as "a stubborn and shrewd scrapper who knows when to charge ahead and when to make a strategic retreat," he may have need of both tactics.

For more than a decade Dr. Henderson has had a ringside seat in watching the battle take shape. He became a member of the House of Delegates in 1937 and of the Board of Trustees two years later; in 1947 he became chairman of the Board. Quietly he has sought to bring medical policy into line with public demand without sacrificing the fundamentals of (1) the physician's freedom and independence and (2) the patient's freedom of choice of physicians. Said he in his acceptance speech: "If we are to endure as a free medical profession we must stand united and present a solid front. We have just begun to fight. With the help of Almighty God, I pledge you that we will continue to fight and we will win." He advocates changing the machinery of medical service to meet conditions, but by "evolution," not "revolution."

Dr. Henderson was born in Garnettsville, Ky., in 1885. With all the determination of his Scotch-Irish heritage, he began carving out his brilliant career in medicine the hard way when he reached Louisville at the age of 21. Various forms of employment kept him at his studies until he received his medical degree from the University of Louisville Medical School in 1909, and he now will become its twelfth graduate to be named president of the American Medical Association. Since 1911 he has been engaged in the practice of surgery in Louisville. He is a past president of the Jefferson County Medical Society and of the Kentucky State Medical Association, a former vice president and president of the Southeastern Surgical Con-

gress and a recent past president of the Southern Medical Association and of the Alumni Association of the University of Louisville. He rendered distinguished service in World War I and World War II.

A man of strong personality, rugged constitution and amazing energy, Dr. Henderson takes off for London, Paris, Rome, Tokyo or Peru with the casual air of one driving over to a neighboring town. In 1947, he helped organize the World Medical Association at Paris and is now one of its councilors. He has inspected Army medical service in Japan, Germany and Austria, and this spring at Lima he helped Latin American physicians strengthen their Pan American Medical Association. He champions sharing this country's medical knowledge with the other nations of the world as ardently as he proclaims the family doctor as the foundation stone of good medicine. His devotion to the cause of the medical profession, his skill in diplomatic negotiation and his financial acumen promise truly great leadership in the hour of medicine's greatest need.

Dr. Seale Harris Honored

A signal honor was bestowed upon Dr. Seale Harris of Birmingham, Ala., at the June meeting of the American Medical Association in Atlantic City. Its House of Delegates chose him as the recipient of the Distinguished Service Medal, its highest scientific award.

This noted son of the South has won international recognition for his research on hyperinsulinism and its control. Within a year after the discovery of insulin, Dr. Harris visited Toronto, where he studied many cases with Banting, Best, Collip and McLeod and witnessed insulin reactions. His observations at that time led him to recognition of the effects in nondiabetic patients of excessive secretion of insulin. Among his many notable contributions to medical literature are chapters on hyperinsulinism, food poisoning and pellagra in various systems of medicine. In 1946 he published a book entitled "Banting's Miracle" and he is now writing a biography of Marion Sims.

Born in Cedartown, Ga., on March 13, 1870, Dr. Harris received his academic schooling at the University of Georgia and his medical training at the University of Virginia. After receiving his degree in medicine in 1894, he practiced twelve

years in Union Springs, Ala., and nine years in Mobile before taking up residence in Birmingham. There he became professor of medicine in the medical department of the University of Alabama, and is now professor emeritus.

A past president of the Southern Medical Association and a former editor of the Southern Medical Journal, this eminent member of the medical profession has served with distinction in many capacities as citizen, soldier and physician. During World War I he was cited by General Pershing "for conspicuous and meritorious service in France." The recent award of the Distinguished Service Medal is fitting recognition of a great Southern physician and citizen whose outstanding contributions to medical science and practice have won for him a lasting place in the annals of medicine.

Church Group Decries Socialized Medicine

The American Council of Christian Churches at its Spring Convention held in Denver late in April of this year stated emphatically, and certainly most commendably, its position "concerning the human body and its relationship to the Creator." This expression, in the form of a resolution unanimously adopted, was deemed appropriate because this church group saw in socialized medicine an outright violation of an amendment to its constitution, which guarantees "the right of the people to be secure in their persons." The resolution follows:

Against Socialized Medicine

For the State to usurp responsibility for the medical care of its citizens, whatever its name and title, constitutes an infringement of human responsibility and individual freedom which God has not given to the State.

God created man for His own glory, gave him a body as a fit organ for his soul, and made man responsible to Him, not to the State, in his care of his body. The State has no right to destroy this relationship, and require by law, force, or other method the submission of the body to its paternal care.

The soul and the body are inseparably connected, parted only by death; and when the State *attempts* such care of the body, it inevitably moves to direct the mind and spirit.

The depravity of man, as taught in the Bible, so aggravates State control as it relates to government officials, politicians, physicians, and patients as to produce a corrupt, inefficient, expensive, bureaucratic and intolerable system.

Socialized medicine in any form, represents, we believe, a clear violation of the Fourth Amendment of our Constitution which guarantees "The right of the people to be secure in their persons."

The battle against State medicine is not for the doctors alone, but it belongs to all Christian people who cherish their own freedom as well as the physician.

1949 A. M. A. Convention

The attendance at the Ninety-Eighth Annual Session of the American Medical Association at Atlantic City in June was in itself history-making for more than 13,000 physicians and nearly 15,000 visitors were registered. This record was second only to the one set at the Centennial meeting at Atlantic City in 1947. The presence of many physicians from foreign countries attested the worldwide interest in this great organization. Widespread public interest in its activities was reflected in the news coverage of the convention. Sixty-five newspaper men and women covered the meeting, the largest number ever to do so.

Dr. Ernest E. Irons of Chicago, long associated with the Council on Pharmacy and Chemistry and with the Board of Trustees, succeeded Dr. R. L. Sensenich of South Bend, Ind., as president. Dr. E. L. Henderson of Louisville, Ky., formerly chairman of the Board of Trustees, was unanimously chosen president-elect, and Dr. Louis H. Bauer of New York became chairman of the Board. Dr. George F. Lull was reelected secretary.

Chicago was selected as the convention city in 1952 and Denver for the Clinical Session in 1950. The next session will be the 1949 Clinical Session in Washington, D. C., December 6-9, and the annual session will take place in San Francisco, June 26-30, 1950.

Representing the Florida Medical Association at the meeting were its two delegates, Dr. Homer L. Pearson, Jr., of Miami and Dr. Louis M. Orr, II, of Orlando. Dr. Pearson is a member of the Judicial Council, and Dr. Orr serves on the Reference Committee of the House of Delegates on Insurance Plans and Medical Service.

Florida was well represented with 124 members of the Association in attendance. The official roster includes the following names:

BRADENTON: Lowrie W. Blake, John E. Granade. COCOA: Walter C. Page. CORAL GABLES: Edward H. Cowell, Glenn H. Heller, C. Howard McDevitt, Jr., William L. Wagener, Jr. FERNANDINA: Benjamin F. Dickens. FT. LAUDERDALE: Burns A. Dobbins, Jr., Elliott M. Hendricks, Thomas L. McKee, Richard A. Mills, Francis D. Pierce. FT. MYERS: Joseph D. Brown. FT. PIERCE: Jerome A. Megna. JACKSONVILLE: John A. Beals, John D. Ferrara, William G. Harris, Gordon H. Ira, Samuel S. Lombardo, Joseph J. Lowenthal, Clarence M. Sharp, Daniel R. Usdin, Ashbel C. Williams. JACKSONVILLE BEACH: Adolph B. Cone.

KISSIMMEE: John O. Rao. LAKELEND: Fred S. Gachet. MELBOURNE: Isaac M. Hay, Theodore J. Kaminski. MIAMI: Samuel Aronovitz, Ernest R. Barnett, Martin S. Belle, Isaac B. Cippes, Benedict A. Cusani, George Ferre, Emmett T. Fitzpatrick, M. Jay Flipse, Roger J. Forastiere, J. Raymond Graves, Carlos P. Lamar, Alfred G. Levin, George D. Lilly, James K. Mc-

Shane, Donald F. Marion, E. Sterling Nichol, Homer L. Pearson, Jr., Wiley M. Sams, George F. Schmitt, Donald W. Smith, Donald G. Stannus, Richard F. Stover, Earl R. Templeton.

MIAMI BEACH: William H. Bernstein, Lewis Capland, Max Dobrin, Harold H. Fox, Elias Freidus, Milton S. Goldman, Max Gratz, Emil M. Isberg, Samuel Kaplan, Saul H. Kaplan, Leo M. Levin, Alexander Libow, Meyer B. Marks, Maurice S. Mazel, David A. Nathan, Julius A. Oshlag, Virgil H. Pieck, Francis A. Reed, Maurice J. Rose, Herman G. Rosenbaum, Milton S. Saslaw, Sol Selevan, Nicholas A. Tierney, David Waltherman, Maurice Zimmerman. MIAMI SPRINGS: Louis C. Pessolano. OCALA: Harry F. Watt. ORLANDO: Chas. J. Collins, Elwyn Evans, Eugene L. Jewett, Clarence W. Lynn, Meredith Mallory, Pleasant L. Moon, Jr., Louis M. Orr, II.

PALM BEACH: Fred E. Manulis, Bailey B. Sory, Jr. PALMETTO: Alva J. Floyd. PANAMA CITY: William C. Roberts. ST. AUGUSTINE: Robert D. Harris, Jr., A. Clark Walkup. ST. PETERSBURG: Arnold S. Anderson, James A. Bradley, Charles K. Donegan, William D. Futch, Norval M. Marr, Orville N. Nelson, George R. Schwartz. SANFORD: Harry Z. Silsby. SARASOTA: John M. Butcher, Thomas C. Garrett, David R. Kennedy, Cecil E. Miller. SEBRING: Leldon W. Martin. TALLAHASSEE: Charles F. James, Jr. TAMPA: Joshua C. Dickinson, Wm. P. Duncan, J. Brown Farrior, Nathan L. Marcus, Alfonso F. Massaro, Thomas F. Nelson, Neal J. Phillips, Joseph D. Scolaro, Burdette Smith, Alvord L. Stone, Mason Trupp, Morris Waisman. VENICE: Talmadge S. Thompson. WEST PALM BEACH: Ralph M. Overstreet, Jr., Herman G. Rose, Saul D. Rotter, William Y. Sayad. WINTER PARK: Ruth S. Jewett.

Graduate Courses Held

The week before the Graduate Short Course was held this year, a four day Advanced Course in Cardiovascular Diseases and Electrocardiography was conducted at the George Washington Hotel in Jacksonville, June 14 to 17, inclusive. There was a total of 58 registrants, which for such a highly specialized course was considered good. Those in attendance were pleased with the type of instruction given.

The Medical Postgraduate Course Committee will meet in the early fall to determine the type of special course in internal medicine to be offered about the same time in 1950. Suggestions from those interested in internal medicine will be welcomed by the Committee and should be sent to the chairman in time for consideration at the next meeting.

The Seventeenth Annual Graduate Short Course was held at the same location, beginning on June 20 and continuing through June 25. The total registration was 123. This number falls about 25 under the average attendance for the last eight years. The type of instruction compared favorably with that offered elsewhere in any medical center. The time was approximately the same as has been chosen each year since the course

was started seventeen years ago.

Both the course in electrocardiography and the Short Course were well publicized for five months prior to their presentation. The Committee was keenly disappointed at the poor attendance at the Short Course. This particular course is designed in its entirety primarily for the general practitioner, and it is the purpose of the Committee to continue the week's instruction for the general practitioner. Nevertheless, the lectures are of such character that any specialist in the field taught would gain each year by attending. Again, the Committee would appreciate any constructive criticisms or suggestions that would help improve the week's graduate instruction and encourage increased attendance.

Medical Postgraduate Course Committee
T. Z. CASON, M.D., Chairman

Education Campaign Materials

Florida doctors now have the means with which they can carry an important message to the people. The medical profession's hard-hitting "grass roots" education campaign is to give the American people accurate information concerning the many advantages of voluntary health insurance over any of compulsory nature. It is now slightly more than six months old. It began with the \$25 assessment of its members by the American Medical Association, and the employment of the public relations firm of Whitaker and Baxter, during the waning days of 1948.

Whitaker and Baxter have maintained from the beginning that this campaign can best be waged by means of pamphlets, which they would provide for the doctors for use in their home communities. These and other materials of like nature have been coming forth in ever increasing numbers in the past few weeks. At this time it may be advisable to take stock of the nature and extent of campaign material available. A summarization of the most important of these, both from the national headquarters of Whitaker and Baxter and the Bureau of Public Relations of the Florida Medical Association, appears to be indicated.

From the national headquarters of Whitaker and Baxter. First, the pamphlets: "The Voluntary Way is The American Way" is a compilation of the fifty most frequently asked questions to-

gether with the answers; "Keep Politics Out of This Picture" is folder type, ideal for doctors' waiting rooms, contains "thumb nail" comparisons between voluntary and compulsory health insurance programs on such matters as costs, benefits and others; "Compulsory Health Insurance—A Message from Your Doctor" is a detailed analysis of the current proposals to socialize medicine; and "Uncle Sam, M. D.," produced by a lay organization, is a comprehensive digest of the arguments against politically controlled medicine. The last named was one of the first issues from Whitaker and Baxter and was mailed directly to each member of the A. M. A. and the Woman's Auxiliary.

The posters: color reproductions of the famous Fildes painting "The Doctor" are available in two sizes. The smaller of these is designed to be suitable for framing and hanging in doctors' offices. Each doctor was contacted directly by Whitaker and Baxter and urged to request one of these posters for his office. The other is larger and intended primarily for placement in hospital waiting rooms. Sufficient posters of that type were obtained by the Association's Public Relations office and distributed to the hospitals throughout the state. Each type of poster carries below the picture a powerful message showing that political intervention between the doctor and patient must be prevented.

The latest campaign ammunition to arrive at this writing is a small dignified sticker for each doctor to attach to correspondence and statements to his patients. It gently reminds the patient that his doctor believes that government-regulated medicine would be harmful to both patient and doctor, and politely requests that he express that opinion to his Senators and Congressman.

To aid those county societies which have the facilities of local radio stations at their disposal there have been prepared radio recordings of speeches opposing compulsory health insurance by Senators Cain of Washington and Ellender of Louisiana. The Bureau of Public Relations of the Association has five sets of these recordings available for immediate issue. Senator Pepper has been broadcasting transcribed talks on various problems confronting the national government. If your local station has been carrying these recordings of Senator Pepper, it probably broadcast number 15 which was on the national health program. That same radio station should be willing to give the local medical society an equal amount of time on the air to present the other

side of the picture. The Cain-Ellender records are admirable for this purpose, providing a hometown doctor or layman cannot be found who will take to the air in person to refute the Senator's arguments.

Due to a terrific organization task and a necessary lapse of time for writing, editing and printing the information from national headquarters, your state campaign committee found it necessary to provide certain materials to get the campaign under way early. Most of these supplementary supplies are still available and are beneficial adjuncts to the flow of material from Chicago. The most important of these are: a comprehensive and detailed set of Speakers' Notes; a pamphlet "The Issue of Compulsory Health Insurance" by the Florida Medical Association's Committee on Public Relations, Dr. Frank G. Slaughter, former Chairman; several thousand postcards, containing a printed message and addressed to the several Congressmen and President Truman, were printed and distributed to the county medical societies (additional cards are not available); copies of the Brookings Report, the Ewing Report and the Hoover Report; various mailing pieces of reprints, copies of speeches, the 12-Point Program of the A. M. A., analysis of bills introduced into the 81st Congress including copies of these bills; and organization and operation suggestions for the carrying out of the campaign on the county society level.

It is expected that this flow of materials from national campaign headquarters to the doctors will continue. It is valuable only so long as it is readily distributed and placed into the hands of those for whom it was intended.

YOUR BLUE SHIELD

Your Blue Shield Plan now processes an average of 875 claims each month for participating physicians with monthly payments amounting to approximately \$48,000.00. In April more people were enrolled in Blue Shield than during any one month in the plan's history. Enrollment at present is over 105,000. It is therefore to be expected that the number of Blue Shield patients will steadily increase, and it is also to be expected that certain problems will arise in the handling of these cases.

In order to simplify as much as possible the doctor-patient relationship, in this and following

issues of The Journal, we will attempt to clarify specific problems which might confront the doctor.

Surgery in Doctor's Office

The Blue Shield contract covers surgery of minor nature performed in the doctor's office with the exception of obstetrical service. It should be noted that it is not necessary to hospitalize all Blue Shield patients for surgery of minor nature in order to receive surgical benefits.

X-ray Benefits

Doctors may be called upon to advise patients how to receive the maximum benefits under their Blue Shield and Blue Cross contracts. We would like to point out that provisions for x-ray service differ under the Blue Shield and Blue Cross contracts. Under the Blue Cross hospitalization contract, a patient must be hospitalized for eighteen or more continuous hours, and the x-ray must be taken in the hospital during this in-patient stay, in order that the patient receive x-ray benefits. Under the Blue Shield surgical contract, x-ray benefits are extended to participating physicians who render x-ray services either to (1) in-patients who receive x-ray services, taken in connection with, or in the diagnosis of surgical services rendered under the Blue Shield plan for surgical care, and (2) patients receiving x-ray services either in the hospital or doctor's office within twenty-four hours of an accident in connection with suspected acute fractures and dislocations.

Anesthesia and Pathology

Under the Blue Shield Plan, anesthesia and pathologic services are covered only when the patient is admitted to a hospital for eighteen or more continuous hours and payment is made only to participating physician not in charge of the case for these services when they are rendered in connection with surgical services rendered under the plan for surgical care during the same period of hospitalization.

Use of Code Numbers for Surgical Procedures

Prompt settlement of Blue Shield claims will be facilitated by indicating on the Doctor's Service Report the identifying code numbers for surgical procedures listed in the plan's Schedule of Benefits. If the surgical services rendered are not identical with those listed in the Schedule of Benefits, the physician should indicate the most closely related procedure found in the Schedule of Benefits and accompany this code number with a detailed description of the services rendered.

Participating physicians desiring information on any phase of the Blue Shield Plan or Blue Shield contract are asked to write the Jacksonville office of the plan, Box 1798. This information will be furnished promptly and will also act as a guide in furthering doctor-plan relationship.

STATE BOARD OF HEALTH

The Policy of the State Board of Health in Dealing with the Medical Profession

The State Board of Health has always planned its medical programs with the advice and assistance of the medical profession of the state. In recent years many organizations and specialties have been formed and at times there has been confusion as to what organization should properly advise the Board on medical matters. In rare instances there has not been uniformity in the expressed wishes of some specialty groups and the county medical society or the Florida Medical Association as a whole. The Board discussed this problem sometime ago and decided that while every effort would be made to carry on their work in a manner agreeable to all medical groups as well as to the public, it was felt proper to give first priority to the advice and wishes of the county medical societies, or committees formed by such societies, and by the Florida Medical Association or duly appointed committees of that organization. It was felt that by following this procedure uniformly there was a greater chance of attaining harmony and avoiding confusion. The State Board of Health will naturally continue to work closely with all medical specialty groups.

It has also been the policy of the State Board of Health for many years to use the county medical society as an advisory body in connection with medical programs carried on within the county. A restatement of this policy may be superfluous but at times we are queried as to what we are doing in such and such a program on a statewide basis. Most of our medical programs vary considerably from county to county so that it is impossible to give a categorical answer to such questions. In some instances activities are carried on in a particular county that would not meet the approval of medical societies in other counties nor of the Florida Medical Association as a whole. It is felt, however, that we are on sound ground when each county health department follows the advice

of the local medical society; and it is further felt that this is the most democratic procedure possible and that the same procedure is followed by the Florida Medical Association itself.

Very truly yours,
WILSON T. SOWDER, M.D.
State Health Officer

Tick Paralysis May Simulate Poliomyelitis

According to an article in the Medical News Letter¹ of the United States Navy, 4 patients with tick paralysis were observed at the Grady Memorial Hospital in Atlanta, Ga. So far as is known, this condition has not been reported in Florida, but has been recognized for many years in the Canadian and American Northwest. Veterinarians are familiar with the condition in this state, and it is said to be a not infrequent cause of paralysis among dogs and even cattle.

It is characterized by elevation of temperature, irritability, weakness of muscles and ataxia. The diagnosis is readily confirmed by the finding of an engorged tick and the prompt recovery of the patient after its removal. The condition apparently occurs most commonly in children and for that reason, and because of the resultant ataxia and paralysis, may lead to an erroneous diagnosis of poliomyelitis.

The ticks reported as involved in the cases described were females of the species *Dermacentor variabilis*, which is a species of hard tick. The symptoms are apparently the result of the injection of a neurotoxin which acts upon the spinal cord and bulbar nuclei.

Treatment after removal of the tick is systemic, and prompt recovery can be expected. Veterinarians report that recovery in animals is speeded by the use of calcium gluconate.

Two Duval county physicians were among the first in the country to be certified by the newly organized American Board of Preventive Medicine and Public Health, Incorporated. Dr. Wilson T. Sowder, State Health Officer, and Dr. Lorenzo L. Parks, Director of the Field Technical Staff, were recently certified as specialists in preventive medicine and public health by this board.

¹ Tick Paralysis, U. S. Navy Medical News Letter, 13:2:8 (May 6) 1949.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

William C. Thomas of Gainesville, local Pilot Club
 Ralph M. Overstreet, Jr., of West Palm Beach, graduating members of local Good Samaritan Hospital School of Nursing
 Francis T. Holland of Tallahassee, local Lion's Club
 Cleland D. Cochrane of Daytona Beach, local Junior Chamber of Commerce
 Louis M. Orr, II, of Orlando, local Junior Chamber of Commerce
 Alphonsus M. McCarthy, Vaughn A. Shaw, Norman E. Williams and Cleland D. Cochrane of Daytona Beach, local Rotary Club (broadcast over Station WNDP)
 James T. Cook of Marianna, local Junior Chamber of Commerce
 Joseph S. Stewart of Miami, Palm Beach Rotary Club
 Taylor W. Griffin of Quincy, local Pilot Club
 Frank G. Slaughter of Jacksonville, National Pharmaceutical Association in Jacksonville
 Frank C. Metzger of Tampa, Clearwater Kiwanis Club
 Arthur J. Butt, Jr., of Pensacola, local Pilot Club
 C. Robert DeArmas of Daytona Beach, local Lion's Club
 F. Gordon King of Jacksonville, local American Legion Luncheon Club
 Walter C. Payne of Pensacola, local Junior Chamber of Commerce
 Frederick K. Herpel of West Palm Beach, local Junior Chamber of Commerce
 James R. Boulware, Jr., of Lakeland, local Kiwanis Club
 Walter C. Payne of Pensacola, local Exchange Club

BIRTHS AND DEATHS**Births**

Dr. and Mrs. Morris J. Levine of Miami Beach announce the birth of a son on April 21, 1949.

Dr. and Mrs. Arthur C. Tedford of Melbourne announce the birth of a daughter on May 26, 1949.

Dr. and Mrs. Henry H. Caffee of Coral Gables, announce the birth of a son, Michael Douglas, on Feb. 5, 1949.

Deaths—Members

Dr. Karl W. Ney, Stuart May 30, 1949
 Dr. Nelson M. Black, Jr., Coconut Grove June 9, 1949
 Dr. Spencer A. Folsom, Orlando June 26, 1949

Deaths—Other Doctors

Dr. William H. Thomas, Jacksonville June 10, 1949
 Dr. Moreton H. Axline, New Port Richey May, 1949

STATE NEWS ITEMS

Members of the Association who were registrants at the Southeastern Surgical Congress held recently in Biloxi, Miss., include: Dr. William D. Sugg, Bradenton; Drs. M. Eldridge Black, John D. Hagood, George C. Tillman, Clearwater; Drs. C. Robert DeArmas, Peter A. Drohomier, Alphonsus M. McCarthy, Daytona Beach; Dr. Charles E. Tribble, DeLand; Dr. Rabun H. Williams, Eustis; Drs. Roland F. Fisher, Alva R. Taylor, William D. Wells, Ft. Lauderdale; Drs. Edwin H. Andrews, John E. Maines, Jr., Gainesville; Dr. Howard G. Holland, Leesburg; Drs. Daniel A. McKinnon, Courtland D. Whitaker, Marianna; Dr. George D. Lilly, Miami; Drs. Harold H. Fox, Cayetano Panettiere, Miami Beach; Dr. Thos. H. Wallis, Ocala; Drs. William O. Fowler, Carl D. Hoffman, Don C. Robertson, Orlando; Dr. George M. Dawson, Palm Beach; Drs. J. Powell Adams, William C. Roberts, Panama City; Drs. Arthur J. Butt, Jr., Frank B. Hodnette, Carol C. Webb, Pensacola; Dr. Madison R. Pope, Plant City; Dr. Julius C. Davis, Quincy; Dr. A. Lamar Matthews, Jr., Sarasota; Dr. James H. Pound, Tallahassee; Drs. Arthur R. Beyer, Leffie M. Carlton, Jr., James C. Griffin, Jr., Tampa; Dr. Lloyd J. Netto, West Palm Beach.

Dr. Joseph S. Stewart of Miami was elected vice president of the Southeastern Surgical Congress which was held in Biloxi, Miss., in May.

Dr. Samuel R. Lamb of Jacksonville attended meetings at the Harvard Medical School in Boston in May.

Drs. W. Jerome Knauer and Shaler Richardson of Jacksonville recently attended meetings of the Wilmer Eye Institute in Baltimore.

During National Child's Week, Drs. J. K. David, Joel Fleet and Hugh A. Carithers of Jacksonville presented short radio interviews on Child Health.

Dr. John R. Browning of Jacksonville recently attended urological meetings which were held at Tulane University of Louisiana School of Medicine.

Dr. Rudolph W. Heath of Hollywood recently took postgraduate study at the University of Georgia School of Medicine.

Dr. Thomas H. Lipscomb of Jacksonville spoke on the importance of the early diagnosis and treatment of cancer before members of the local Optimist Club in June. He spoke on the same subject before members of the Jacksonville Beaches Lion's Club.

Dr. Raymond R. Sessions of Kissimmee has returned to his office after taking a postgraduate course at the Cook County Hospital in Chicago.

Dr. Edward T. White, Jr., of Pensacola spoke on stomach ulcers and their treatment at a meeting of the local Lion's Club in June.

Dr. H. Marshall Taylor of Jacksonville attended meetings of the American Laryngological Association and of the American Otological Society which were held in New York City in May.

Five members of the Association were registrants at the May meeting of the American Psychiatric Association which was held at Montreal, Canada. They are Drs. James L. Anderson, Herman Selinsky and Edward H. Williams of Miami; Dr. I. Leo Fishbein of Miami Beach, and Dr. Lowell S. Selling of Orlando.

At the annual meeting of the American College of Radiology which was held in Atlantic City in June, Dr. John A. Beals of Jacksonville was elected a member of the Board of Chancellors of that organization for a term of four years. Other Association members who were registered at the meeting were Dr. Elliott M. Hendricks of Ft. Lauderdale and Dr. Joshua C. Dickinson of Tampa.

Dr. Hewitt Johnston of Orlando announces the reopening of his office at 320 North Main Street. His practice is limited to eye, ear, nose and throat.

WANTED BY RADIOLOGIST: Florida opportunity sought by Board Diplomate, 34. Exam for Florida license June 1949. Dr. I. Isaacs, 410 St. Marks Avenue, Brooklyn 16, N. Y.

WANTED TO BUY: X-ray machine for diagnostic work. Used, if in good A1 condition, 100 M.A., two tubes, tiltable. Write 69-27, P. O. Box 1018, Jacksonville, Fla.

PRACTICE FOR SALE: Growing north Florida town of 5,000. Grossed \$20,000 last year. Specializing. Write 69-26, P. O. Box 1018, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Berk, Lester I., Miami Beach
Blinski, Maurice, Miami
Brooks, Clyde, Coral Gables
Canipelli, Joseph, Jacksonville
Hedrick, Donald W., Tampa
Hendricks, Anne L., Ft. Lauderdale
Henry, Jimmy F., Melbourne
Huey, Thomas F., Jr., Ft. Lauderdale
Klass, Erna K., Miami
Malone, John M., Green Cove Springs
Neill, Robert G., Orlando
Nix, Dillard L., Raiford
Petteway, Charles H., Lakeland
Ryon, Thomas N., Miami
Toomey, John A., Miami
Weil, Leonard L., Miami Beach

COMPONENT SOCIETY NOTES

Alachua

All members of the Alachua County Medical Society have paid Association dues for 1949.

Bay

At the June meeting of the Bay County Medical Society, Dr. Amsie H. Lisenby presented the scientific program. He gave a review of two surgical cases.

All members of the society have paid Association dues for 1949.

DeSoto-Hardee-Highlands-Charlotte-Glades

The June meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held at the Simmons Hotel at Wauchula. The scientific program was presented by Drs. Chas. McC. Gray and C. Frank Chunn of Tampa who spoke on "Carcinoma of the Lung." Dr. Gray considered the subject from the roentgenologic aspect and Dr. Chunn spoke on the surgical aspect.

Members present included Drs. Harold S. Agnew, Godfrey L. Beaumont, Henry P. Bevis,

Miles A. Collier, George F. Highsmith, Merle C. Kayton, Charles H. Kirkpatrick, Carl J. Larsen, Gordon H. McSwain, Leldon W. Martin, Harold E. Parker, Wesley S. Pyatt, Zaven M. Seron, John A. Simmons, and James G. Smith, Jr. In addition to Drs. Gray and Chunn, Dr. Frank S. Liddy, a member of the staff of the Florida State Hospital at Arcadia, was a guest.

Madison

The first meeting of the newly-chartered Madison County Medical Society was held on June 3 in the home of the president, Dr. A. Franklin Harrison. The scientific portion of the meeting was preceded by dinner.

Marion

Members of the Marion County Medical Society plan to hold joint meetings during July and August with members of the staff of Monroe Memorial Hospital. At the June meeting of the society, held at the "1890 House" in Ocala the following members were present: Drs. William H. Anderson, Jr., Bertrand F. Drake, Edwin C. Hanson, Eaton G. Lindner, John N. Moore, Robbins Nettles, Eugene G. Peek, Jr., Ralph E. Russell, Robert E. Thompson and Harry F. Watt. Dr. Jack M. Waldrep was a guest.

Pasco-Hernando-Citrus

The entire membership of the Pasco-Hernando-Citrus County Medical Society has paid 1949 dues to the Association.

Pinellas

At the June 6 meeting of the Pinellas County Medical Society which was held at the Detroit Hotel in St. Petersburg, Dr. Whitman H. McConnell presented a paper entitled, "Electric Shock Comes of Age." Dr. Albert R. Frederick was in charge of the scientific program.

OBITUARIES

John Thomas Bradshaw

Dr. John T. Bradshaw of San Antonio died on May 22 in Zephyrhills at the home of his son, Dr. Donald G. Bradshaw, after an illness of three months. He was 78 years of age.

Dr. Bradshaw was born in Calvary, Ky., in 1870 and in his early childhood moved with his parents to St. Paul, Kan., where he received his

elementary education. He was graduated from the St. Louis University School of Medicine in 1904, and practiced medicine in Shawnee, Okla., before moving to Florida and locating at San Antonio. For many years he served as mayor of San Antonio. Twenty years ago he opened offices in Dade City, where he practiced continuously until his last illness.

A first lieutenant in the medical corps during World War I, Dr. Bradshaw was a member of the Gordon M. Crothers Post of the American Legion, Dade City. He was a charter member of the San Antonio Chapter, Knights of Columbus, and a member of St. Anthony's Catholic Church in San Antonio.

Dr. Bradshaw was a past president of the Pasco-Hernando-Citrus County Medical Society, a member of the Florida Medical Association, and a fellow of the American Medical Association.

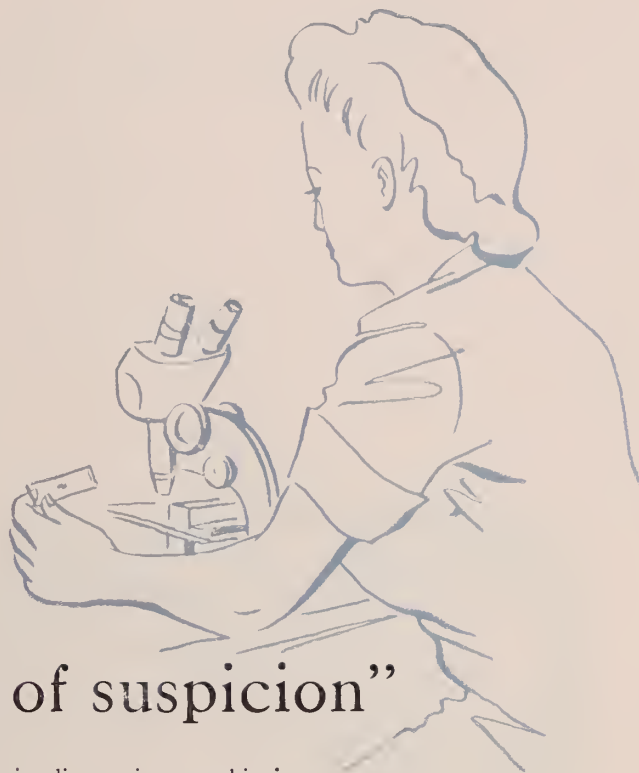
Survivors include his widow, Mrs. June T. Bradshaw of San Antonio; five children by a former marriage, Dr. Virgil T. Bradshaw and Dr. Sam A. Bradshaw of Tampa, Dr. Donald G. Bradshaw of Zephyrhills, Mrs. John E. Herndon and Mrs. William White of Tampa; six grandchildren, and a great-grandchild.

BOOKS RECEIVED

A CENTURY OF MEDICINE IN JACKSONVILLE AND DUVAL COUNTY. By Webster Merritt, M.D. Price, \$3.50. Pp. 220. Illustrations 44. Gainesville, Fla.: University of Florida Press, 1949.

Physicians and laity alike will find in this engaging narrative a most important contribution to Florida's medical and historical lore. With the sure and forthright touch of the true historian, Dr. Merritt presents in panoramic review the fascinating events, towering personalities and progressive movements of the entire nineteenth century as they pertain to medicine in Jacksonville and Duval County. His exhaustive research and painstaking efforts have brought to light in highly readable form history long obscured, owing to loss of official records in the Jacksonville fire of 1901. In sifting out the facts for this entertaining and accurate account, he pictures the physician as community builder and harbinger of progress as well as practitioner of medicine, and his facile pen loses none of the drama of the terrifying yellow fever and other epidemics or the gala events of the times. With equal skill he traces the foundation and early history of the Florida Medical Association and of the Florida State Board of Health.

As related editorially in this issue of The Journal, the author is a brilliant scholar and able historian who has made notable contributions to Florida history in The Journal and in historical publications. His book is profusely illustrated throughout its twenty chapters and makes a valuable addition to any library, particularly that of the physician.



"A high index of suspicion"

The difficulties and pitfalls in diagnosing amebiasis are stressed frequently in medical literature.

"... despite the absence of a history of dysentery, amebiasis must be considered in the differential diagnosis of many bizarre clinical syndromes. . . . A high index of suspicion is the keynote of early diagnosis."¹

In acute or latent forms of amebiasis, Diodoquin may be employed over prolonged periods. This high-iodine-containing amebicide "is well tolerated. . . . The great advantage of this simple treatment is that in the vast majority, it destroys the cysts of *E. histolytica* and is, therefore, especially valuable in sterilizing 'cyst-carriers.' It can readily be taken by ambulant patients and, therefore, eliminates the necessity of hospitalization."²

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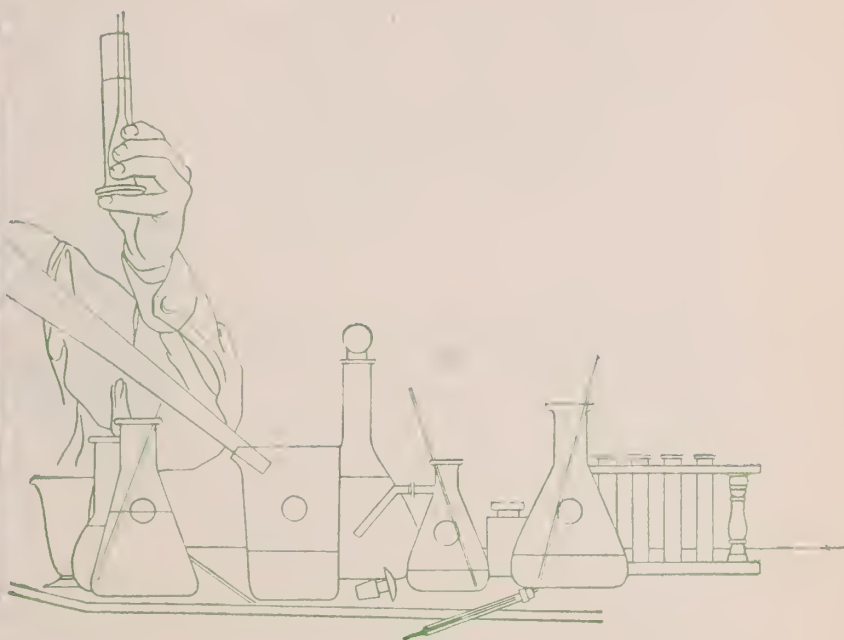
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RESEARCH IN THE SERVICE OF MEDICINE
G. D. Searle & Co., Chicago 80, Illinois

1. Warshawsky, H.; Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis, *New England J. Med.* 235:678 (Nov. 7) 1946.
2. Manson-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," *Glasgow M. J.* 27:123 (May) 1946.

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Surgical Anatomy & Clinical Surgery, Two Weeks, starting September 26, October 24.

Surgery of Colon & Rectum, One Week, starting September 12, October 10.

Esophageal Surgery, One Week, starting October 10.

Thoracic Surgery, One Week, starting October 3.

Breast & Thyroid Surgery, One Week, starting October 10.

Fractures & Traumatic Surgery, Two Weeks, starting October 3.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 26, October 24.

Vaginal Approach to Pelvic Surgery, One Week, starting September 19, November 7.

OBSTETRICS—Intensive Course, Two Weeks, starting September 12, November 7.

MEDICINE—Intensive General Course, Two Weeks, starting October 3.

Gastroenterology, Two Weeks, starting October 24.

Gastroscopy, Two Weeks, starting September 26, October 24.

Electrocardiography & Heart Disease, Four Weeks, starting September 7.

DERMATOLOGY—Formal Course, Two Weeks, starting October 24.

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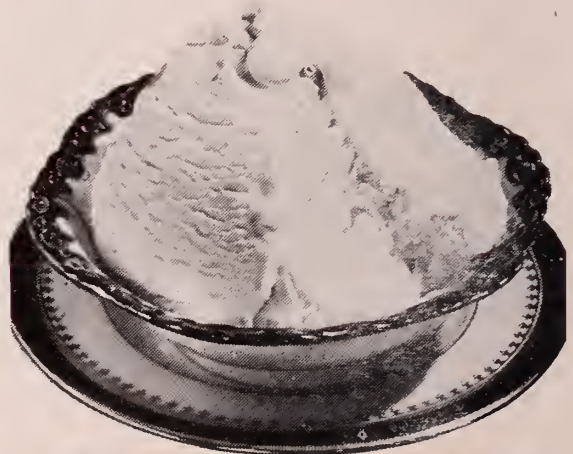
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While I'm waiting for a haircut a couple of days ago, Slim Hartman lets slip with a crack about those "foreigners" who recently moved in down by the depot.

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Slim gets a little red and you could see that Doc had him. "And the reason they came here," he goes on, "was to find freedom to do and think as they wanted to, just so long as they didn't tramp on any of the rights of the other fellow."

From where I sit, America became the great land it is today through our being tolerant of different people and different tastes—whether it's a taste for square dancing or waltzing, radio or movies, goat's milk or a temperate glass of sparkling beer.

Joe Marsh

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Feinberg, S. M.: Postgrad. Med. 3: 92 (1948).

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Levin, L.; Kelly, J. F., and Schwartz, E.:
New York State J. Med. 48: 1474 (1948).

The antihistaminic drugs "are valuable additions to our armamentarium, but do not . . . supplant the specific desensitizing injections."

Brown, G. T.: M. Ann. District of
Columbia 16:675 (1947).

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Rosen, F. L.: J. M. Soc.
New Jersey 45: 390 (1948).**DIAGNOSTIC AND TREATMENT SETS**

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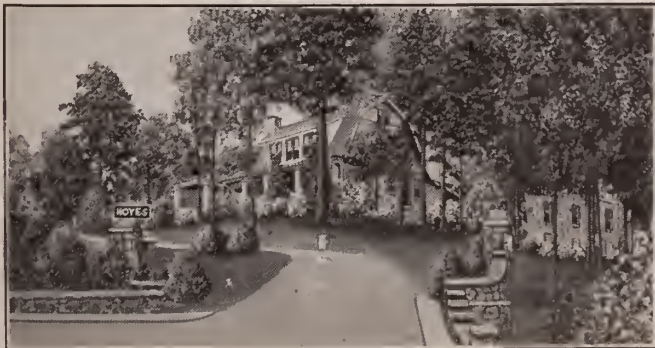
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Quincy, Oct. 24, 1949
Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Palatka, Oct. 26, 1949
Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Sebring, Oct. 27, 1949
Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	Ft. Lauderdale, Oct. 28, 1949
Florida Specialty Societies			
Surgical Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Supt., Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Intern. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Intern. Practice of Med.			" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Industrial & Railway Surgeons			" "
Otorhinology & Psychiatry			" "
Obstet. and Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthalm. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society			" "
Ophthalmological Society			" "
Ophthalmic Association, State			" "
Ophthalmologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Ophthalmological Society			" "
Ophthalmological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewitt, Tampa	" "
Florida—			
Physic Science Exam. Board	Robert A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	Homer L. Pearson, Jr., Miami	Frank D. Gray, Orlando	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Robert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, April, 1950
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
American Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loranz, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	April 5-7, 1950
Southeastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., 1950
Southeastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5, '50
Southeastern Surgical Congress	R. J. Wilkinson	B. I. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
Florida Coast Clinical Society	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	Pensacola, Oct. 6-7, '49

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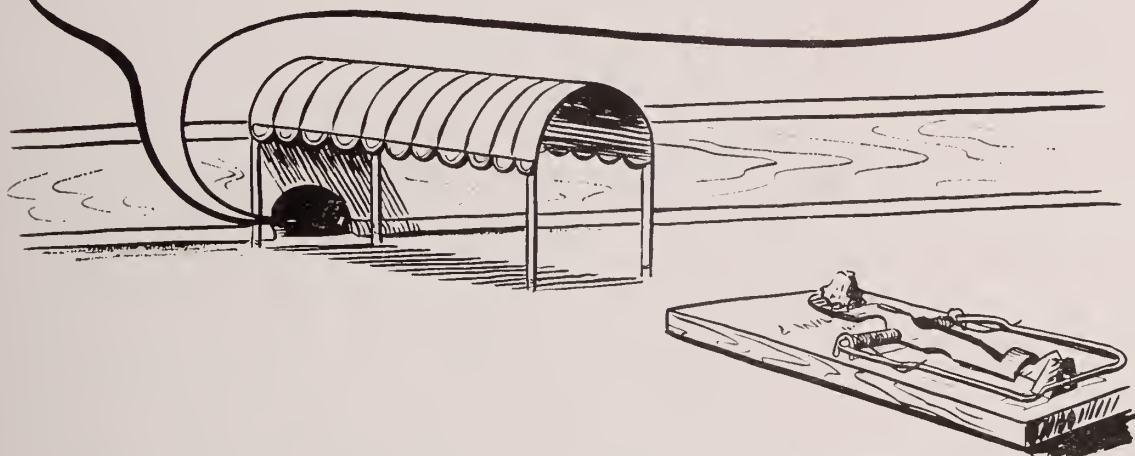
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					Total	Paid	
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	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Port St. Joe	3rd Tuesday Odd Months	7	6	A-1-50 William P. Hixon, M.D. Pensacola
	Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	19	18	
	Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. ChIPLEY		5	100%	
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	44	42	A-2-51 Taylor W. Griffin, M.D. Quincy
	Suwannee	Joshua M. Price, M.D. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		5	100%	
	Madison	A. Franklin Harrison, M.D. Madison	Merwin E. Buchwald, M.D. Madison		5	100%	195
	Taylor *Dixie-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	
B	Alachua *Bradford, Gilchrist Union	Alva L. Cobb, Jr., M.D. 50a W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	40	100%	
	Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	248	227	
	Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	28	26	B-3-50 Charles C. Grace, M.D. St. Augustine
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	7	100%	
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	Orange *Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	136	132	
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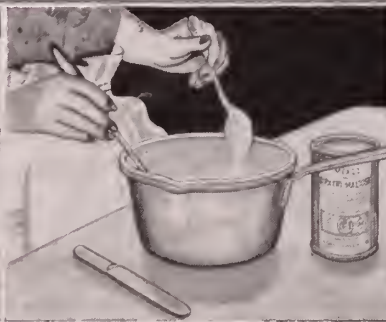
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2 Stir in Dextri-Maltose while water is hot.



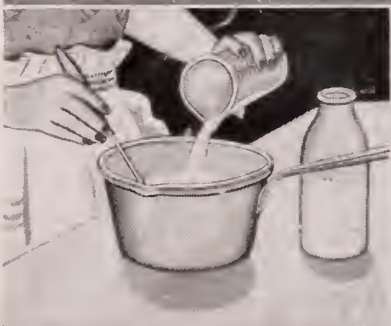
3 Add evaporated milk and stir.



OR

WITH WHOLE MILK

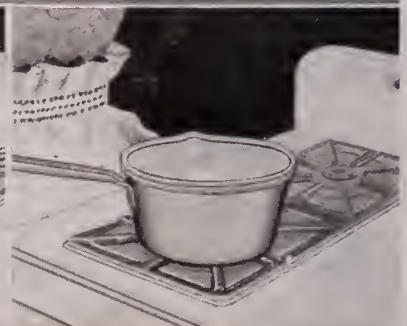
1 Mix whole milk and water.



2 Heat until almost boiling and stir in Dextri-Maltose.



3 Boil gently for three minutes.



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IN THIS ISSUE

Cancer of the Breast

Edward Jelks and A. T. Kennedy



Intrathoracic Goiter

Duncan T. McEwan and Robert E. Zellner



Fifth Anniversary of Florida's Blue Cross Plan: Dr. Hawley Speaks

Page 164

(Complete Table of Contents Page 128)



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SEPTEMBER, 1949

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CONTENTS

SCIENTIFIC ARTICLES

- Cancer of the Breast: a Comparison Study of Findings in a Charity Clinic and in a Private Clinic, Edward Jelks, M.D., and A. T. Kennedy, M.D. 143
Early Closure of Burn Areas, Michael L. Mason, M.D. 149
Intrathoracic Goiter, Duncan T. McEwan, M.D., and Robert E. Zellner, M.D. 154
New Drugs, Frank C. Metzger, M.D. 157

ABSTRACTS OF MEDICAL ARTICLES

- True Hermaphroditism; Endocrine Studies in a Case of Ovotestis, John C. Weed, M.D., Albert Segaloff, M.D., W. B. Wiener, M.D., and J. W. Douglas, M.D. 159
Primary Hypertrophy and Hyperplasia of the Parathyroid Glands As a Cause of Hyperparathyroidism, H. Milton Rogers, M.D., and F. Raymond Keating, Jr., M.D. 159
Mistaken Surgical Diagnoses in Hookworm Disease, Duncan McEwan, M.D., James G. Economon, M.D., and Robert E. Zellner, M.D. 159
Slipped Epiphysis in the Adolescent Hip: a Reconsideration of Open Reduction, Paul H. Martin, M.D. 160

EDITORIALS

- The "Something for Nothing" Boomerang 162
British Opinions on Socialization of Medicine 163

COMMENTARIES

- Fifth Anniversary of Florida's Blue Cross Plan: Dr. Hawley Speaks 164
American Heart Association Research Awards 167
Diabetes Detection Drive Progresses 167
Health Legislation Before the Eighty-First Congress 167

GENERAL FEATURES

- Officers and Committees 160, 161
Your Blue Shield 168
National Education Campaign 169
Births, Marriages and Deaths 169
State News Items 169
New Members 170
Component Society Notes 170
Spencer Augustus Folsom (Obituary) 171
Rayburn Nelson Joyner (Obituary) 171
Thomas Albert Neal (Obituary) 171
Nelson Miles Black, Jr. (Obituary) 172
Woman's Auxiliary 172
Books Received 176
Schedule of Meetings 189
List of County Medical Societies, Presidents and Secretaries 190

This Journal is not responsible for the opinions and statements of its contributors.

in hay fever...

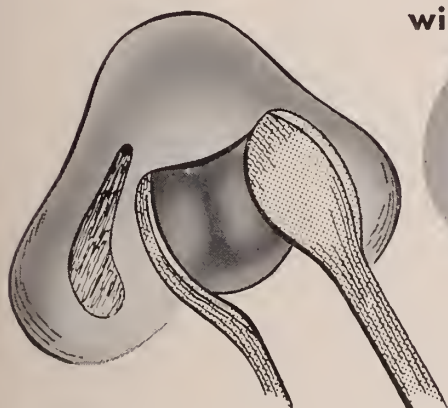
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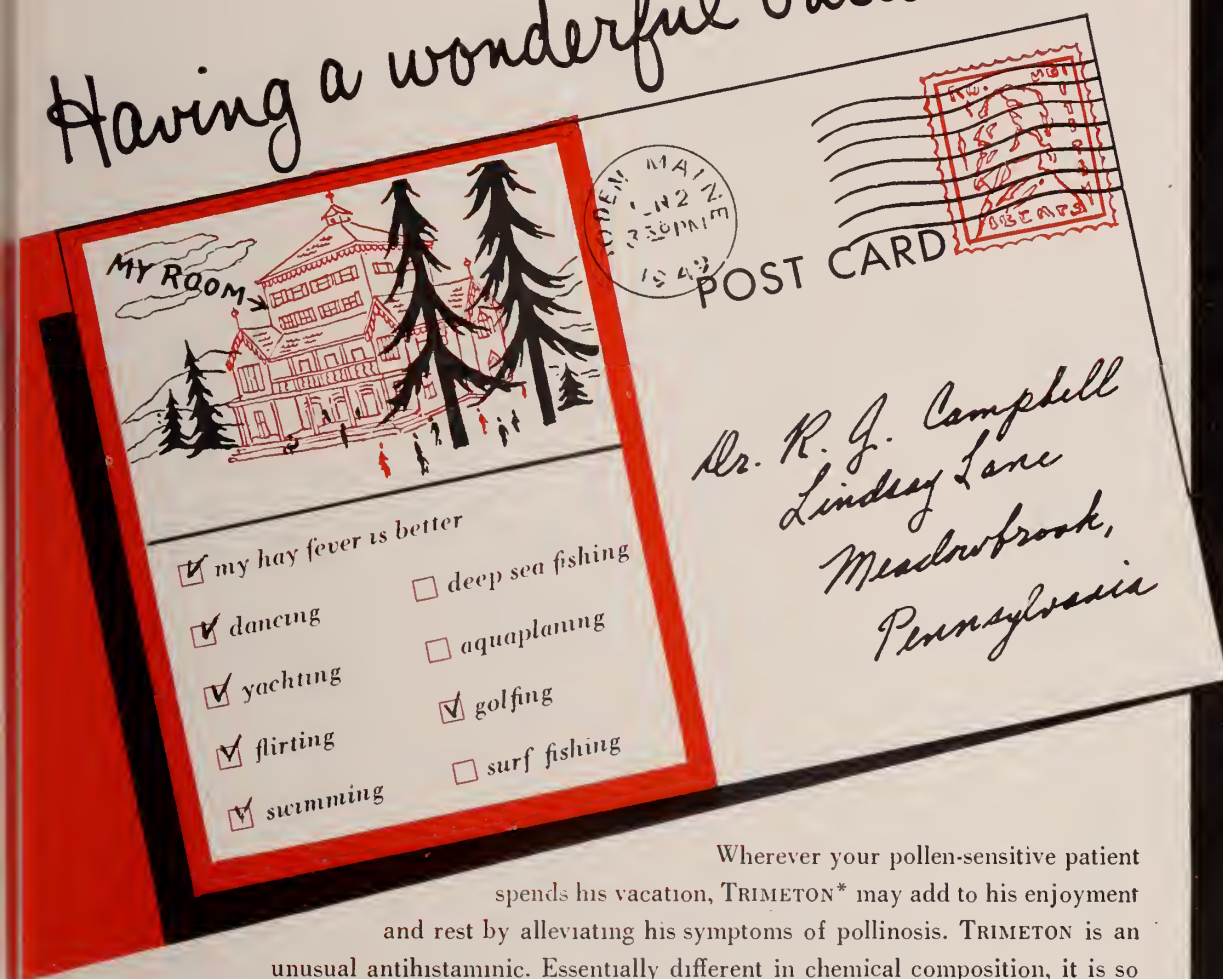


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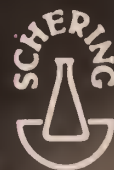
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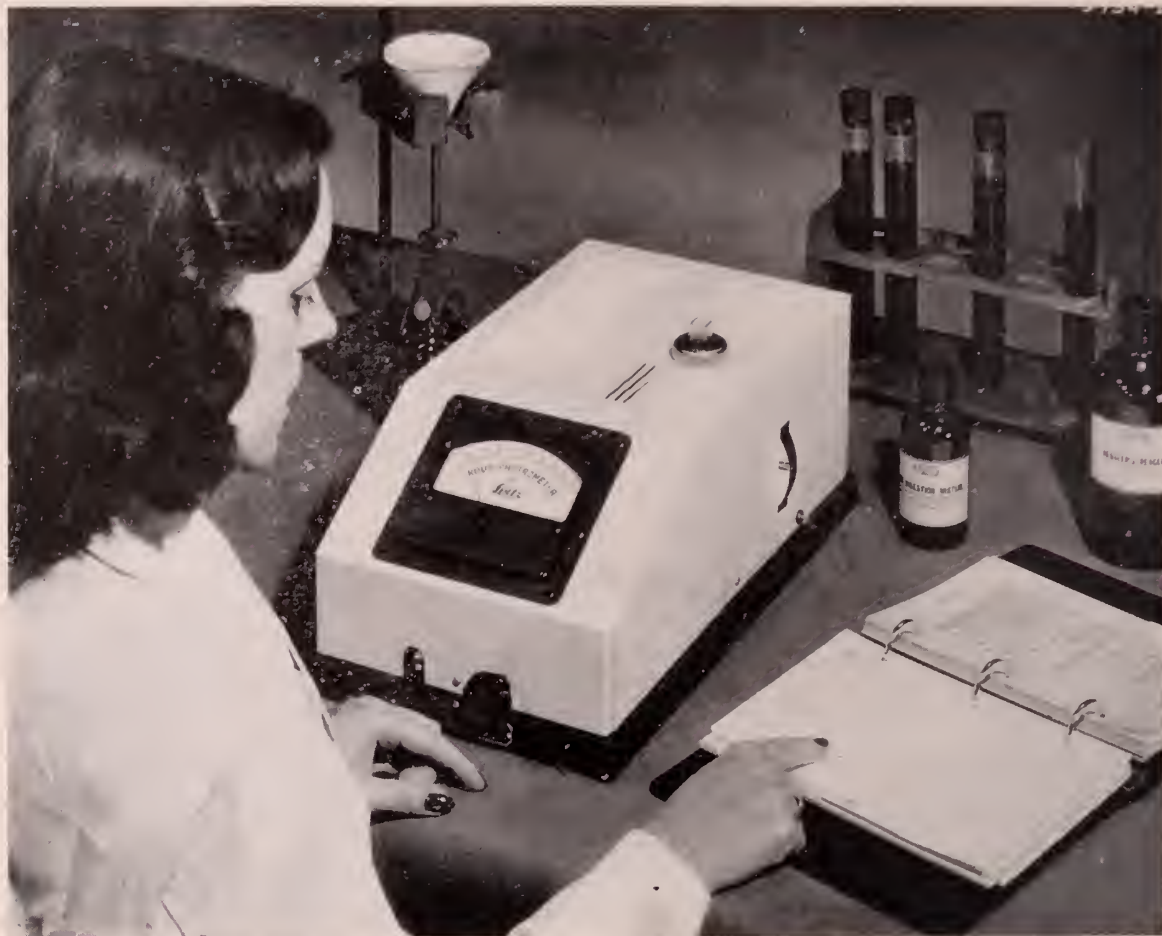
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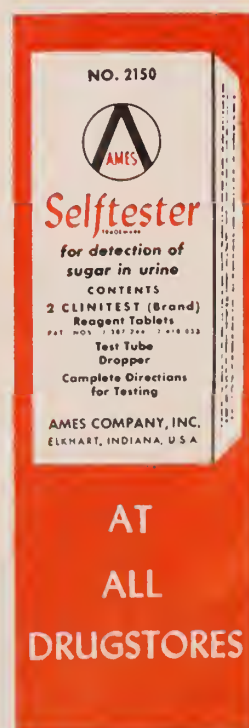
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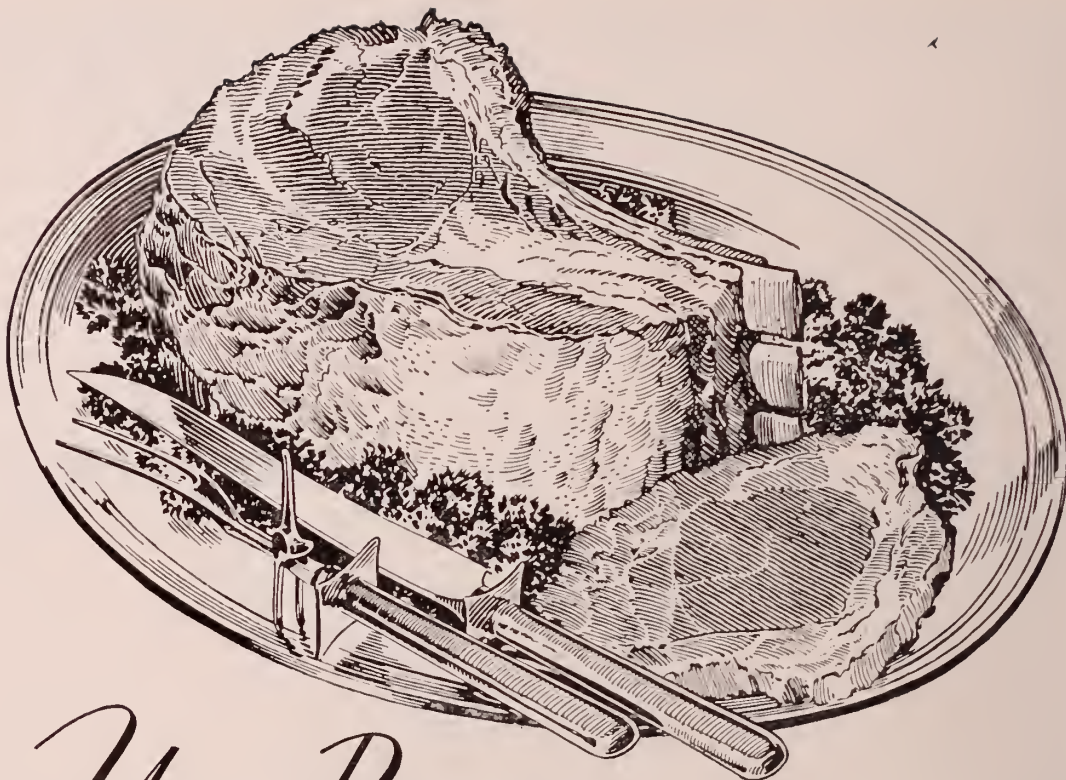
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† Wilkerson, H. L. C. and Krall, L. P.: Diabetes in a New England Town, Journal of the American Medical Association, 135:209 (Sept. 27) 1947.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

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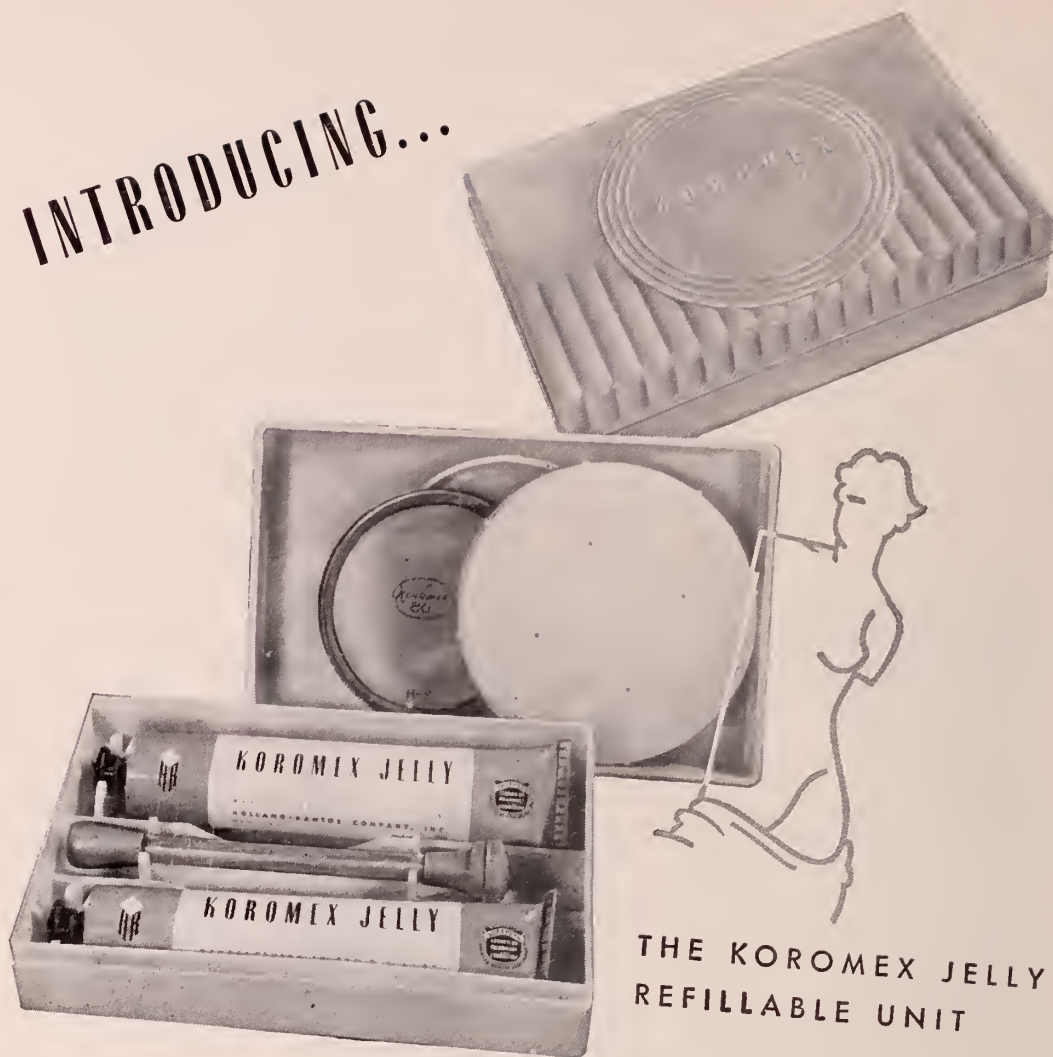
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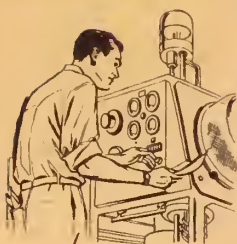
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LILLY SPECIALISTS SERVE THE MEDICAL PROFESSION

Cancer of the Breast: a Comparison Study of Findings in a Charity Clinic and in a Private Clinic

EDWARD JELKS, M.D.

AND

A. T. KENNEDY, M.D.

JACKSONVILLE

During the year 1948, 2,929 deaths in the state of Florida were due to cancer, and there were 281 deaths in Duval County which were attributed directly to this disease. It is further estimated that over 1,000 people in Duval County are living with some form of cancer in their system. The number of deaths can be reduced if an early diagnosis is made and the proper treatment instituted. The death rate is necessarily high in many forms of cancer because it arises in some organ which is deep within the body and thus is discovered too late to effect a cure. This should not be true of the type reported in this study as the breast is on the surface of the body and is easily accessible for examination by both the patient and the physician.

In a previous report,¹ a study of 100 cases of cancer of the breast treated at the Duval County Hospital was described, and an attempt was made to analyze the poor results. In this presentation, the patient as she presented herself in a charity clinic is compared with the patient in a private clinic. Altogether, 418 operations were performed at the two institutions with the question of malignant disease under consideration. Comprising the charity group were 113 consecutive cases seen during the years 1927-1946. In 100 of these cases the disease proved to be malignant. There were 305 cases in the private group, seen during the years 1921-1946, and in 116 of these cancer was present. The patients included in the private group represent the number receiving treatment for this disease at the Riverside Hospital since its organization into a clinic in 1921. Differences between the two will be discussed. Treatment and results will be compared.

The age groups were about the same in the two institutions, as shown in table 1. It will be noted that the disease occurred most frequently between the ages of 40 and 49 years. The number be-

Table 1.—Age

Age Groups	Riverside Hospital	Duval County Hospital	Total
20-29	2	6	8
30-39	13	11	24
40-49	35	38	73
50-59	28	22	50
60-69	28	18	46
70-79	8	4	12
80-89	2	1	3

tween the ages of 20 and 29 years is 8 or almost 4 per cent, and the number below the age of 40 totals 32 or 15 per cent. These percentages are rather surprising and serve as a reminder that it is never safe to say or think that a patient does not have cancer of the breast because she is not old enough.

The first major difference in the two groups can be seen in table 2 and figure 1. Thirty-eight or 32.8 per cent of the Riverside Hospital group were seen within one month after their first symptom referable to the breast occurred. Only 1 pa-

Table 2.—Symptoms, Their Duration, and Chief Complaint

	Riverside Hospital	Duval County Hospital	Total
Duration of symptoms when first seen			
1 month or less	38	1	39
2 months	10	7	17
3 months	10	14	24
4-6 months	23	21	44
7-12 months	19	23	42
13-24 months	11	18	29
25-48 months	3	7	10
49 months or more	2	9	11
First abnormality noticed by patient			
Tumor	103	91	199
Pain	4	4	8
Discharge	4	5	9
Chief complaint			
Tumor	64	37	131
Pain	17	46	63
Discharge	3	3	6
Ulceration	2	11	16

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 11, 1949.

Table 4.—Treatment

	Riverside Hospital	Duval County Hospital	Total
Operative treatment			
Tumor only	1	3	4
Breast only	12	11	23
Breast and axilla	3	15	18
Breast and muscle	—	1	1
Radical resection	99	55	154
Irradiation treatment			
Preoperative roent- gen therapy	12	—	12
Postoperative roent- gen therapy	38	—	38
Roentgen therapy only	—	1	1
Radium and roentgen therapy only	—	1	1
Supportive therapy only	1	13	14

therefore one must be as radical as possible at the onset. In recent years none of the incomplete operations have been done, except in a few instances in which a simple mastectomy (breast only) was performed for palliation.

In the treatment of these patients, as with all patients with cancer of the breast, a radical mastectomy is the procedure of choice if a cure is to be obtained. Many of the patients coming to the Duval County Hospital were in a far advanced state and only 55 per cent were considered as candidates for this form of therapy. The remaining patients received palliative and supportive measures. The operability of the patient is an individual matter and depends on several factors. First, the tumor must not have spread locally beyond the area surgery can surround. Second, the patient must not have distant metastases. Third, the patient's physical constitution must be such that it is safe to perform the radical operation. This last requirement has been greatly extended with the recent advances which make all patients safer for surgery. In each case the surgeon, the internist, the anesthetist and the pathologist form a team to decide the best course to pursue.

When it has been decided that the patient is operable, the operation which is performed is based on the surgical principles laid down by Halsted.² A description of the technic used follows:

The initial skin incision is made with the thought of completely surrounding the tumor growth area. No consideration is given to closure of the wound. In a few cases, closure has been necessarily supplemented by a split-thickness skin graft. The skin flaps are cut thin and even and the dissection is carried to the following limits:

1. Medially to 2 or 3 centimeters beyond the mid line.
2. Superiorly to the clavicle and the cephalic vein.

3. Laterally to 2 or 3 centimeters beyond the anterior border of the latissimus dorsi muscle.
4. Inferiorly to the fascia overlying the rectus abdominis muscle.

By incising through the overlying fat, the pectoralis major muscle is exposed and the lower three-fourths of the fibers are separated from the upper one-fourth, down to the attachment on the humerus. At this point, the lower fibers are cut across and the muscle retracted medially. In order to obtain better exposure of the pectoralis minor muscle, parts of the pectoralis major muscle are then detached from the sternal margin. With care to avoid damage to the vein beneath it, the pectoralis minor is cut across at its attachment to the coracoid process on the scapula. Then the two muscles are retracted and the costocoracoid membrane is cut, thus exposing the axilla to its highest point.

The axillary dissection is begun at the apex and carried laterally. The vein is dissected free of all fat and the branches of the artery and the vein are individually doubly clamped, divided and ligated. Any lymph nodes that are found clustered about the vein are removed and labeled.

The long thoracic nerve and the subscapular vessels are removed if it appears that the surrounding tissue is involved.

When the anterior border of the latissimus dorsi muscle is reached, the dissection is carried down to the serratus anterior muscle. Next, the origins of the pectoral muscles on the ribs are freed by sharp dissection and this is carried laterally, removing the fascia of the serratus anterior muscle and the upper part of the rectus sheath.

Thus, the entire breast with the axillary contents, the pectoral muscles and the fascia of the serratus anterior muscle and the upper portion of the rectus sheath are removed in one mass. The wound is then irrigated with warm normal salt solution. A soft rubber tissue drain is usually placed in the axilla through a stab wound.

In most cases the wound can be closed and grafting is not necessary. When this is not possible, a split-thickness graft is used to cover the defect at the time of operation.

Preoperative and postoperative roentgen therapy was used at Riverside Hospital, but did not appear to increase the five year survival rate. Thirty-eight received postoperative roentgen treatment, and 18 or 48 per cent survived five years. In the group receiving preoperative roentgen treatment, the number of patients was too small to be of value. It was used in the more unfavorable cases.

There were 2 cases of sarcoma and 3 cases of Paget's disease in the entire series. The remainder fell into some class of carcinoma. In 38 of the Riverside Hospital cases, the pathologist reported that the disease had progressed as far as the axillary lymph nodes. This number is to be compared with 55 cases at the Duval County Hospital in which there was extension to the axilla at the time of surgical intervention.

There was a low incidence of a history of trauma at both institutions. A history of cancer in the family was obtained in 23 cases of the entire series, which represented only 10.6 per cent. The right and left breasts were found to be in-

volved about equally.

Table 5.—Type of Lesion and Other Data

	Riverside Hospital	Duval County Hospital	Total
Type of lesion			
Carcinoma	113	98	211
Paget's disease	2	1	3
Sarcoma	1	1	2
Lymph node involvement	36	55	91
Muscle involvement	—	4	4
Miscellaneous			
Previous injury or trauma	5	16	21
Family history	18	5	23
Right breast	57	54	111
Left breast	59	51	110
Both breasts	—	5	5

In table 6 we have tried to correlate a study of the involvement or extension of the disease to the lymph nodes in the axilla. For the purpose of study, the disease was classified into Clinical Stages I and II and Pathologic Stages I and II. Clinical Stage I includes the cases in which the disease was limited to the breast itself. In Clinical Stage II axillary lymph nodes were detected by at least one examiner. Pathologic Stage I is not a histologic grading or an index of the degree of malignancy, but is based on failure to find microscopic metastatic axillary disease. In Pathologic Stage II are the cases in which the pathologist reported microscopic evidence of extension of the cancer into the axillary lymph nodes. It was found that the clinician is often wrong in his preliminary classification of the condition into Stage I or Stage II. In the two institutions, 89 patients were found clinically to have palpable axillary lymph nodes. After operation and examination by the pathologist had been performed, it was learned that 32.5 per cent of this group did not show extension of the disease to the axillary nodes.

Table 6.—Clinical and Pathologic Correlation of Lymph Node Involvement

	Riverside Hospital	Duval County Hospital	Total
Operative cases			
Palpable	34	55	89
Involved	17	42	59
Not involved	17	12	29
Not stated	—	1	1
Not palpable	72	30	102
Involved	21	11	32
Not involved	51	16	67
Not stated	—	3	3

On the other hand, and certainly more important, is the fact that of 101 patients coming to operation in which none of the clinicians that had examined the patient were able to demonstrate axillary nodes, 31.5 per cent showed evidence microscopically of metastatic disease in the axilla. Thus, it seems that the clinician will be wrong in his impression about one third of the time. This is significant enough to emphasize that each patient must have a thorough and complete operation.

Table 7 presents the crude survival rates following radical mastectomy. The operative mortality at the Riverside Hospital was 1.01 per cent. The mortality at the Duval County Hospital for this operation was 18.2 per cent. Thus, we see that this is in itself a factor affecting the survival rate at the Duval County Hospital. The five year survival rate at the charity clinic was 22.7 per cent. Even if the operative mortality is removed, the corrected rate is still only 28.5 per cent. The uncorrected five year survival rate of patients treated by radical mastectomy at the Riverside Hospital was 56.5 per cent. The crude ten year survival rate at the Duval County Hospital was 5.25 per cent, while at the Riverside Hospital, it was 44.5 per cent. Six of the patients treated at the Riverside Hospital survived twenty years or more after operation.

Table 7.—Crude Survival Rates

	Riverside Hospital	Duval County Hospital
Five years	56.5%	22.7%
Ten years	44.5%	5.25%

Table 8 presents the survival rates according to classification into clinical and pathologic stages. It can be seen that in following a large group of patients, there is a fairly close correlation in the ultimate survival percentages between the two classifications. The figures at the Riverside Hospital are more indicative as they represent a larger number of cases. In the private clinic, 65 per cent of the patients whose disease was classified as Clinical Stage I survived five or more years and 63 per cent of those in whom it was classified as Pathologic Stage I also survived five years. Although we have shown that the clinician is wrong about one third of the time in his clinical impression of whether or not the disease has spread to the axillary lymph nodes, it seems that his errors

occur in both directions and tend to balance. Thus, although a pathologic classification is more accurate and probably a better one upon which to base a prognosis in an individual case, the entire clinical picture will give about the same results.

Table 8.—Five Year Survival Rates

	Riverside Hospital	Duval County Hospital
Clinical Stage I	65%	50%
Clinical Stage II	41%	10%
Pathologic Stage I	63.0%	26.7%
Pathologic Stage II	37.5%	20.7%

It therefore behooves us to strive constantly to improve ourselves as clinicians by developing diagnostic ability in the physical examination of patients. It is for this reason we considered it appropriate to include in this discussion a resume of our method of examining the breast.

Examination and Early Diagnosis

In the examination of a patient's breast, the classical signs of cancer must be discarded and minimal changes looked for. Inspection and palpation will give the information necessary for arriving at a diagnosis, and, therefore, transillumination and roentgen study are not routinely employed.

1. Inspect the breasts with the patient in the sitting position; note any difference in the size of the two breasts, difference in the height of the nipples, retraction of the nipple, any bulging or dimpling. We do not see nipple retraction as an early finding.
2. Palpate the breasts with the flat of the hand and with the finger tips. Determine the location, size, shape and consistency of the tumor.
3. Examine the breasts with the patient in the supine position, using both inspection and palpation as described.
4. Try to demonstrate skin attachment by the use of side lighting or a slanting light and gentle manipulation of the tumor with the fingers from all sides. Often we have been able to demonstrate dimpling by this method when we could not do so with a direct overhead light. The mobility of the tumor and the skin over it is thus carefully determined. We consider dimpling as an

early sign and one to which we attach great significance.

5. Examine both axillae and supraclavicular areas carefully.

In the final analysis, any lump in the breast deserves a biopsy in the operating room with a rapid microscopic determination by a competent pathologist. Preparations should be made for the radical operation, and this should be carried out immediately if the report of the tissue examination is one of malignant disease.

Conclusion

Cancer of the breast occurs more frequently in the young woman than one would ordinarily suppose.

If the patient will go to her physician as soon as she discovers a lump in her breast, the rate of cure can be increased.

Skin attachment or dimpling is an early finding in carcinoma of the breast.

Radical mastectomy is the treatment of choice, and if a cure is to be obtained, it must be thorough and complete in every detail.

The clinician is wrong about one third of the time in his classification of the disease with regard to the palpation and involvement of the axillary lymph nodes. He must, therefore, approach the problem with an open mind and perform as complete an operation as possible in each and every case.

A comparison of the survival rates between the two institutions serves as an illustration that many more patients can be cured if they receive proper treatment early.

It follows that early diagnosis is paramount and that the old signs and symptoms of cancer of the breast often mean that the patient will receive only palliative therapy. For this reason, early and minimal findings have been emphasized to give a new concept of the diagnosis of cancer of the breast. Any definite lump or tumor in the breast deserves careful investigation.

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Early Closure of Burn Areas

MICHAEL L. MASON, M.D.

CHICAGO

A few days ago in a discussion of present day surgical problems with a well known abdominal surgeon, the care of burns was suggested as a problem worthy of study. The general and complex physiologic disturbances attendant upon burns were noted, and the difficulties of the local care were discussed. A remark was made to the effect that burns demand a great deal of personal care and attention, that the initial treatment of the patient with severe third degree burns is only a small part of the management; that preparation of that patient for early skin grafting often demands frequent careful aseptic dressings and that it is rarely possible to delegate this care to another for it must be the personal responsibility of the surgeon himself. To this general summation of the problem this surgeon's answer was, "No thanks, none of that for me. I served my apprenticeship in burns when I was an intern."

A burn is an open wound due to heat, and if we surgeons broaden our definition slightly, we can add to heat such agents as acids, alkalis, electricity and abrasive trauma. If we consider the burn an open wound, we develop a logical concept of care which is essentially that of open wound care. The same principles of treatment apply. It is only in their application that we meet up with difficulties.

For the sake of simplicity we may reduce the principles of the local care of the burn to four:

1. Protection of the burn from further trauma and contamination.
2. Cleaning of the traumatized surface of contaminants and debris.
3. Removal of devitalized tissues.
4. Closure of the burn.

In the case of the lacerated or crushed wound the application of these principles is relatively simple and generally admitted, and they form the basis of wound care today. In the case of the burn, however, treatment has become so fogged by tradition, and the seeming difficulties of application of sound general principles are so great that

burns are usually considered apart from other wounds. Their care is often given over to an assiduous but inexperienced nurse or intern. One factor which has tended to complicate the matter of local care, particularly in the severe burn, is the development of burn shock, which may come on suddenly and often unexpectedly and which is frequently treated exclusively, to the detriment of the local condition. Obviously burn shock is deserving of serious attention and immediate treatment, but local care cannot be neglected even in the seriously burned patient if we are to achieve acceptable end results. Later in the course of the severe burn there develop other general disturbances, largely nutritional and hematopoietic in nature, and these are often given priority care over local management. These general disturbances must also receive proper attention and are not to be minimized. The local and general care of a burn complement each other, and neither can be neglected.

Protection of the Burn

Without minimizing the significance of the general management, I should like to discuss briefly the local care of the burn and to explore the possibilities of applying the four general principles of care to them. The first tenet is that of protection of the burn surface from contamination and trauma. A burn when received is a fairly clean wound, not because the burn itself has any significant sterilizing effect but because the skin surfaces do not ordinarily harbor virulent pathogens. The skin is, of course, not sterile, but we have learned from a study of other open wounds, and Colebrook has shown conclusively, that in case of burns the wound invaders we fear come in later as secondary contaminants from sources such as the nose and throat of nurses, doctors, attendants and other patients, from the dust of hospital wards, fingers and unsterile coverings. These are the sources of contamination and these can be guarded against. Prompt covering of a burn with a sterile or at least a clean dressing will protect it from secondary contamination until the patient can be brought to emergency room or hospital for definitive care. The smearing on of grease and salves or baking powder even for minor burns is contraindicated,

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Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 11, 1949.

complicates treatment and often introduces invasive organisms.

After the burn patient reaches the hospital or emergency room, the same protection from contamination must be given the burn as is given to any open surface. All examinations and treatment must be rendered under the strictest of aseptic conditions. When the burn is uncovered for primary treatment, operating room conditions should obtain. All attendants and the patient himself should wear caps and masks, and the cleansing should be carried out under strict asepsis. All subsequent dressings also should be done with aseptic care, including masking surgeon, assistants and patient, handling dressings with forceps and keeping the fingers off the burned surface. Ideally, burns should be dressed in isolated rooms or cubicles as free of dust as they can be made and not in open wards where cross infection is likely to occur. As Colebrook emphasized, burns become infected because bacteria are introduced from other people, rarely because of the presence of virulent bacteria initially on the burn surface.

Cleansing of Traumatized Surface

The second principle of burn care is the cleansing of the wound and the removal of debris. The burn surface, just as any other open wound, harbors a few bacteria, mostly fairly benign, dirt of other sorts and foreign material. The surface can be rendered surgically clean simply by washing it as the surgeon washes his hands before operation with soap and water. This washing is not done with a scrubbing brush but with soft cotton squares, using nonirritant white bar soap and sterile water. It is done gently but carefully and does not require an anesthetic. Even young children experience little or no discomfort from washing providing it is done in a warm room free of drafts.

In the case of extensive burns, with shock present or impending, the cleansing must often be rapidly performed or may require a delay of an hour or so until shock therapy can be instituted. With a severe burn, however, my associates and I make it a practice to start intravenous fluid (blood or plasma) on admission so that while the initial cleansing is being carried out, fluid replacement is flowing into the veins. At the time of cleansing loosened tags of skin and blisters are removed. Following this cleansing, we are in a position to consider the removal of devitalized tissue, which is the third indication in the treatment of the burn.

Removal of Necrotic Tissue

Removal of tissue irreparably destroyed by the burn must be carried out at one time or another before healing can take place. Theoretically it could be removed at once as part of the initial care. There are certain reasons, however, why immediate excision is seldom feasible. One of the most cogent reasons is that it is practically impossible to determine the extent and depth of a burn when it is first seen. The surgeon has a pretty good idea that certain areas are at least second degree, but the exact extent of second and third degree is usually impossible to determine. Unless, therefore, we are dealing with very small burns, where a slight excess in excision is of small moment, primary excision on this ground is not feasible. Also, in burns of any extent, the patient is either in shock or in impending shock and is scarcely in a position to withstand a serious operation with a general anesthetic and with the blood loss attendant upon both excision of the burn and removal of skin grafts which should logically accompany such excision.

Primary excision being therefore seldom permissible, the removal of dead tissue must be delayed until such time as the situation is entirely clarified and the patient in condition to withstand somewhat more energetic treatment.

After cleansing, therefore, the wound is covered with a voluminous pressure dressing. The application of the pressure dressing requires some experience. The cleansed surface is first covered with a layer of fine-meshed gauze saturated in petrolatum. The grease has no particular virtue in itself except that it permits somewhat easier removal later. Over these dressings are placed a few thicknesses of gauze moistened in saline solution to permit surface drainage, and then over the whole are placed large amounts of fluffed gauze or mechanics' waste, sea sponges or foam rubber to form a thick resilient basis for the dressing. Over this mass of material are then laid abdominal pads, and then the whole is bandaged on snugly with woven elastic bandages or stockinet. When the hands or feet are burned, the surgeon should be sure the digits are separated by dressings before applying the pressure. The dressings should extend well beyond the visible extent of the burn; for example, for burns of the hand the lower half of the forearm as well as the hand should be covered. Burns of the trunk, chest or buttocks require voluminous dressings and constant care to maintain satisfactory pressure, but are amenable to it.



Fig 1.—Burn of right and left thighs from red hot metal rod with femoral nerve damage of right thigh. Treated by compression dressings and by excision of necrotic skin and muscle at dressing changes. Ready for skin graft three weeks after burn. (Courtesy of Dr. Harvey S. Allen).

Burns of the face, neck and scalp should also be covered with a pressure dressing, leaving only the nose and mouth and usually the eyes uncovered.

These large dressings serve not only to protect the wound from contamination and to help splint it, but the pressure itself serves a beneficial purpose. There can be no doubt but that it helps to control the swelling to a certain extent and thus helps to minimize fluid loss. A most important function of the dressing also is that it helps to immobilize the area, and it is also a comfortable dressing. It cannot, however, be put on and neglected for days without attention. It must be inspected daily, and if it has loosened, it must be snugged up with fresh bandages or even fresh pads applied over the whole dressing and bandaged firmly over it. It is not removed for a week or ten days unless some complication arises. There is one exception to this rule in case of the face, when the pressure dressing is usually removed on the fourth or fifth day and ordinarily not reapplied.

Since clear delineation of areas of third degree burn is evident by the end of seven to ten days, it is about this time that the surgeon seriously considers compliance with the third indication in the treatment of burns, that is, the removal of devital-

ized tissue. The fact that it has been necessary to postpone this in the early stages of burn is no reason why a vigorous aggressive action should not be taken now. Once removal of necrotic tissue is permissible, it should be accomplished as quickly as possible.

There are several methods by which this removal can be accomplished. The surgeon will find at the time of the first dressing that areas of second degree burn are covered with loosely adherent crusts which may be easily removed. Third degree areas may show slough which may fall off or be easily removed at this time. With deep burns, however, the slough will be densely adherent. These adherent sloughs would require weeks to separate spontaneously, but their removal may be hastened in several ways.

We may dress the burn daily or every other day, excising at each dressing with scissors or knife slough not too firmly adherent. By this means most burns except those with especially deep necrosis may be rendered free of necrotic tissue in from ten days to two weeks. These dressings are done with the greatest of care under strict asepsis and must usually be done by the surgeon himself or by a specially trained assistant. They cannot be entrusted to nurses or unskilled interns. It is

an aggressive attack on the burn, the purpose of which is to promote the removal of necrotic tissue as quickly as possible. These dressings are just as much a part of surgical treatment as any operative procedure. The dressings applied are compression dressings, similar to those used after initial care, and are bandaged on snugly and firmly. It has been helpful to moisten these dressings with saline solution. It is a purposeful procedure and is not designed just to dress an infected area. Too often it has seemed to me that burns are dressed for weeks and months with no other idea in mind than that some kind providence will step in and heal them gradually. The indications at this phase of burn care are to get rid of the slough as soon as possible and all our efforts should be actively designed to do just that.

Some surgeons have thought that necrotic tissues may be more rapidly removed by the use of certain acid solutions which seem to promote separation of the slough. Of the various solutions used pyruvic acid, as recommended by Harvey, has been extensively tried. We have used it, but it has not seemed to us to favor more rapid separation than Dakin's solution. In our hands it has proved painful to the patient. Some surgeons believe that the use of pyruvic acid or any solution on burns depends for its action on moisture rather than any specific activity of the solution itself. It may be that moisture favoring a moist gangrene hastens slough separation.

A method of slough separation which we have come to use more and more has been that of early excision. This is in contrast to immediate excision, which I have discussed in a previous paragraph. By the seventh to the tenth day areas of slough are well established, and the surgeon can easily distinguish dead from living tissue. At this time if we elect to perform excision, the first dressing is done in the operating room with the patient under an anesthetic. All slough is carefully excised, and the excised areas are immediately covered over with another voluminous pressure dressing. This excision leaves a healthy raw surface free of slough on the seventh to the tenth day after the injury.

Closure of the Open Area

The fourth indication in the treatment of burns is the closure of this raw area. Our efforts up to now have been aggressively directed toward the cleansing of the burn and the removal of slough. As soon as slough removal has been accomplished, the surgeon must strive just as aggressively to

cover over these raw surfaces with skin grafts. With conservative measures of removal the surface is usually ready for grafting by the eighteenth to twenty-first day. If early surgical excision is practiced on the seventh to the tenth day, the surface is ready for skin grafting on the tenth to fourteenth day after injury and is often healed by the twenty-first day. Immediate grafting after excision is seldom possible because of the bleeding from the recipient area. The extent to which we may cover raw surfaces with grafts is limited only by the availability of donor sites from which to obtain split skin grafts. If very large surfaces require coverage, several sessions of skin grafting are often necessary. Under such circumstances several "crops" of skin, two or occasionally three, may be removed from the same donor site. In such cases an interval of three to four weeks must elapse between graftings. The surgeon must be prepared to remove skin from such unconventional sites as the abdominal wall and chest since these are often the only unburned areas available.

General and Local Care Interrelated

Little has been said about the general care of the burn patient, not that it is unimportant but because I wish to stress local care. It has seemed to me that we still see too many patients whose burn is painfully dressed day after day until it heals spontaneously after many months or until chronic granulations pile up so thick that only deep excision will permit one to graft the surface. While a severe burn is a difficult situation with which to deal, it becomes much easier if the surgeon has some definite goal in mind and pursues it diligently. His final goal is to get the burn healed, and both the local and general care are actively directed toward that end. It becomes a problem in wound healing. Efforts directed exclusively toward correcting fluid, protein and hematopoietic balances are of no significance if the burn remains unhealed. It is often forgotten too that correction of nutritional and blood imbalances cannot be accomplished unless the local process is healed. They go hand in hand, each complementing the other. So long as large raw surfaces persist, correction of low blood proteins can scarcely be accomplished; as long as blood proteins and hemoglobin are low, healing powers are low, and healing of wounds is slow. Both problems must be attacked simultaneously and aggressively.

Summary

In resume, the problem of care of a burn is the problem of the open wound which resolves itself

into that of wound-healing. There are four indications to be met in the local care of a burn, namely, (1) protection of the burn surface from further injury and contamination; (2) cleansing of this surface; (3) removal of the necrotic tissue produced by the burn; (4) closure of the open area (with skin grafts) at the earliest possible moment. These indications are met by immediate covering of a burn with dressings to prevent contamination and by maintaining this aseptic protection throughout all stages of care until the burn is healed.

The acute burn is cleansed carefully with soap and water, following which a voluminous pressure dressing is applied. Removal of slough and necrotic tissue is accomplished as soon as demarcation has become definitely established, usually by the seventh to tenth day. This removal may be achieved by daily moist pressure dressings, often aided by Dakin's solution or pyruvic acid, which further spontaneous separation of slough. A more rapid method of slough removal is accomplished by actual surgical excision on the seventh to tenth day. By whatever method this removal is accom-

plished, the raw surface should be covered with skin grafts as soon as a healthy granulating area develops. With the daily dressing method, this grafting may be achieved by the eighteenth to twenty-first day. If excision is practiced, the surface is ready for grafting on the tenth to fourteenth day.

The general care of the patient cannot be neglected. Fluid, protein and hemoglobin balances must be restored. But the surgeon must remember that he is restoring these factors to promote healing of the wound and also that the open wound is itself the biggest deterrent to proper nutritional restoration.

The local care of the burned area must be aggressively planned and purposefully carried out with one end in view, that of getting the burn healed as quickly as possible. It is a procedure in which the surgeon or a trained and interested assistant must take an active part. Probably nowhere in surgery is cleanly surgical care so vital as in the local management of the burned area.

154 East Erie Street.

Medical District Meetings

The chairman of the Council, Dr. Russell B. Carson, has just announced that the dates of the four Medical District meetings have been officially set by the Council as follows:

Quincy, 2:30 p.m., Monday, Oct. 24, 1949

Palatka, 2:30 p.m., Wednesday, Oct. 26, 1949

Sebring, 2:30 p.m., Thursday, Oct. 27, 1949

Ft. Lauderdale, 2:30 p.m., Friday, Oct. 28, 1949

Intrathoracic Goiter

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AND

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Intrathoracic goiter has been variously defined as a goiter which is contained entirely within the chest,¹ as one whose greatest diameter as shown by roentgenogram is below the upper aperture of the thoracic cage,^{2a} and as one which extends down to or near the arch of the aorta.³ The first is an anatomic definition and goiters of this type are rare, while the latter are clinical definitions and such goiters are not uncommon. Since goiters contained entirely within the chest have much in common in symptomatology, diagnosis, and management with those the greater portion of which is contained in the chest, the term intrathoracic goiter is generally applied to both types of goiters.

The mechanism whereby a goiter becomes intrathoracic is well understood. The thyroid is bound anteriorly by the prethyroid fascia and the ribbon muscles of the neck which insert into the sternum. Posteriorly it lies on the prevertebral fascia. This position places the thyroid in a fascial plane containing no bottom. Upon swallowing, coughing, or flexion and extension of the neck, the thyroid moves up and down in the neck. A small adenoma may pass in and out of the thorax repeatedly until it grows large enough to become incarcerated within the chest. Wendel⁴ reported the case of a "plunging goiter," a goiter which moved through and back out of the thoracic aperture, suddenly becoming trapped within the thorax and producing sufficient tracheal compression to necessitate emergency thyroidectomy to relieve the pressure. An intrathoracic goiter may consist of the entire gland or an extension of one or both lobes or the isthmus into the chest cavity.

Goiters of all types are less common throughout the South than elsewhere in the United States.⁵ While statistics are not available as to the frequency of intrathoracic goiter in the South, Mahorner⁵ reported 248 cases of goiter among a total admission of 52,863 patients to Charity Hospital, New Orleans, in one year, an incidence of 0.46 per cent. Lahey^{2b} pointed out that it takes years for a goiter to develop and still more years for it to become intrathoracic. The incidence of intrathoracic goiter was reported by this author as 10

per cent in 13,000 cases; by Hunt³ as 2.7 per cent in 651 cases.

Symptoms

The symptoms of intrathoracic goiter may be related to overactivity of the thyroid gland, to pressure of the gland on the trachea, esophagus, and great vessels of the upper thorax and neck, or to both. Generally, the surgeon's attention is directed toward the abnormal location of the gland by the patient's complaint of difficult breathing. We recently reported the case of a woman treated for three weeks for asthma who had extreme tracheal compression from an intrathoracic goiter into which such massive hemorrhage had occurred that an emergency thyroidectomy had to be performed. Sometimes inability to breathe in the recumbent position will be the chief complaint. A chronic dry cough or a feeling of a "lump in the throat" may be the only symptom. Engorgement of the veins of the neck or edema of the face may occur in advanced cases. In any case of tracheal compression from a mediastinal tumor an intrathoracic goiter should be suspected, especially when roentgen examination of the chest shows deviation of the trachea from the midline. Roentgen examination of the superior mediastinum should be made in every case of suspected intrathoracic goiter, not only for diagnostic purposes but to indicate the size and extent of the goiter.

Treatment

The treatment of intrathoracic goiter is surgical removal. The complications of this disease are of such gravity that we believe a physician is rarely, if ever, justified in telling a patient that he should do nothing about the goiter as long as it does not bother him. Adenomatous goiters without hyperthyroidism may suddenly become toxic.⁶ Carcinoma of the thyroid may develop.^{2c} Hemorrhage into the capsule may be of sufficient magnitude to cause tracheal occlusion.⁷ A more insidious, yet equally dangerous, complication is the damage done to the central nervous system and to

the entire body by long-standing pressure on the great veins in the neck and on the carotid sinuses.^{2b, 6}

Preoperative preparation, especially in those patients with toxicity, requires considerable forethought and careful planning. The problem of management of toxicosis has been immensely simplified since the advent of propyl thiouracil. This drug is relatively safe and, used with proper care and supervision, is invaluable in preparing toxic patients for thyroidectomy. Cole⁸ stated that the use of iodine and thiouracil in the preparation for operation for toxic goiter is the "greatest single factor in the maintenance of low mortality rate." The blood of all patients receiving propyl thiouracil should be examined at frequent intervals to detect the occurrence of neutropenia or anemia. Lahey^{2d} reported the incidence of reaction to propyl thiouracil as 2 per cent in 670 patients. While this percentage is lower than the 9 per cent reported when thiouracil was used, it is sufficiently high to indicate that propyl thiouracil should be used with care. Because of the delayed effect on the hematopoietic system that propyl thiouracil sometimes has, the administration of this drug should be discontinued for approximately ten days prior to the proposed date of operation in order that any deleterious changes in the blood picture may be detected and treated preoperatively; this precaution avoids having them occur as a post-operative complication. After the patient's metabolic rate has been reduced to normal, iodine is given for a period of ten to fourteen days to reduce the vascularity of the gland at the time of operation. In the occasional patient who cannot tolerate propyl thiouracil, roentgen ray radiation over the sternum should be applied until the metabolic rate has been satisfactorily diminished.

Since intrathoracic goiters are always of long standing, it is important that the patient be in the best physical condition possible for him. As has been pointed out by Thompson,⁹ Cole⁸ and others, the best single criterion for judging a toxic patient's response to treatment is his gain in weight. This is more important than basal metabolism rate, pulse rate, or any other one factor. It should be emphasized, however, that the patient's entire condition should be evaluated. Cole⁸ believed that any of the following is a contraindication to operation: (1) failure to gain weight; (2) resting pulse rate above 110; (3) basal metabolism rate of 50 per cent above normal; (4) any untreated complications such as cardiac decompensation and diabetes.

In a patient with pronounced tracheal compression it is sometimes difficult to evaluate the degree of toxicity of the gland. We recently had this point forcefully brought out in the case of a 66 year old woman who had had an intrathoracic goiter for twenty or more years and who, when first seen, had such difficulty in breathing that determination of the basal metabolic rate was not even attempted. This patient was so apprehensive that it was difficult to evaluate the meaning of the rapid pulse rate. Upon checking the pulse rate on several occasions while she was asleep and while under anesthesia, it was concluded that the elevated pulse rate was due to toxicity rather than to apprehension as was previously believed. The preparation of the nontoxic patient is much less difficult, but should be just as carefully planned. In case of doubt as to the toxicity or nontoxicity of the gland, it is safer to treat the patient as though the gland were toxic. Rea¹⁰ reported an incidence of thyroid crisis of almost 2 per cent in 155 cases of clinically nontoxic adenoma of the thyroid removed at the University of Minnesota Hospital between 1940 and 1944.

We generally prefer our patients to arrive in the operating room drowsy but not asleep. Accordingly, premedication usually consists of a barbiturate approximately two and one-half hours preoperatively followed by demerol and atropine one and one-half hours preoperatively. The choice of anesthetic agent will vary with the surgeon and with the experience of the anesthetist. Lahey^{2a} was of the opinion that the removal of an intrathoracic goiter should never be attempted without the prior insertion of an intratracheal tube. Cyclopropane has many proponents as the anesthetic agent of choice in thyroid surgery. Nicholson¹¹ stated that "cyclopropane should not be used as the sole anesthetic agent, not even for induction, for patients who are severely toxic or have shown any abnormality of the cardiovascular system." We are still more conservative and prefer not to use it at all in such cases. Intravenous pentothal sodium and local injection of procaine, or nitrous oxide-oxygen-ether have proved satisfactory in our experience. The choice of the time of operation is especially important. As is well known, a toxic patient's condition varies from day to day, and one is inviting trouble unnecessarily when he operates on a patient on the down grade.

The operative procedure has been described by Lahey,^{2a} Hunt,³ and Blain and DeMatteis.¹ The technic is essentially the same as that for the re-

removal of a cervical goiter with certain important modifications. Lahey^{2a} stated that the combined cervicothoracic approach is not necessary and should not be employed even with goiters which are obviously too large to be removed intact through the thoracic aperture. A low collar line incision is made, the skin flaps are reflected back, and then the ribbon muscles are transected and retracted laterally. The superior pole of one lobe of the thyroid is dissected out, and the superior thyroid artery and vein are ligated. The lobe is then retracted medially, the superior laryngeal nerve is identified, and the middle thyroid veins are ligated. Ligating the inferior thyroid artery and vein may be considerably more difficult. Lahey^{2a} devised a method whereby he inserts the index finger behind the adenoma and slips it down through the thoracic aperture, if possible, to the base of the gland and then gently forces the gland up into the neck. The inferior thyroid artery he either ligates as it is exposed or, before trying to deliver the gland from the chest, identifies the artery with his finger along the gland, clamps it, and ligates it. In those goiters too large to be removed from the chest intact, the upper pole of the gland is incised after the superior and inferior arteries have been ligated, and the semiliquid contents are aspirated. This procedure reduces the size of the gland sufficiently to permit its passage through the thoracic aperture. Following the removal of the gland, the cavity which it occupied is loosely packed with gauze to control oozing. This is gradually removed over a period of six to eight days. Postoperative care is

determined in part by whether or not the gland had been toxic, but does not otherwise differ from the postoperative treatment of any thyroidectomized patient.

Summary

The symptoms, complications and management of intrathoracic goiter have been discussed. It is our opinion that if all adenomas of the thyroid are removed early, intrathoracic goiter is a complication of thyroid disease which may be prevented.

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**The Scientific Department of The Journal
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New Drugs

FRANK C. METZGER, M.D.

TAMPA

Among the problems facing the physician engaged in active practice there may be numbered the ever present problem of new drugs and new methods of treatment. Should he adopt them immediately, he soon becomes known as "too changeable." When he does not, he is often labeled an "old fogey" or an "ultraconservative." How, then, is the physician in the field, who from force of circumstance cannot make his own investigations or use the new drugs in controlled series of cases, to avoid the pitfalls which lie in either extreme?

I have observed that practically all new drugs or new methods pass through four stages. Understanding the reasons for these stages has helped me withstand the undue pressure the public places upon the man of medicine.

Every physician has seen new remedies appear in the medical picture, fall into disuse and then undergo a period of actual revulsion; later he finds their use confined to a limited field. Some, of course, are ultimately abandoned. Thus they pass through four definite stages:

Stage 1. The introductory stage of widespread, almost hysterical use. The first reports are usually excellent.

Stage 2. Results of controlled series, studied by agencies properly equipped to eliminate or evaluate other factors, begin to appear in print. Side effects, varying from nausea to death, are reported. The public finds that continuous taking of the drug no longer gives the relief experienced at first. The percentage of good results reported in stage 1 drops sharply.

Stage 3. Side effects become more and more frequent. Public opinion swings to the opposite extreme. Physicians select with more care the cases in which the drug or treatment is to be used. Published results no longer vary so widely in percentage of cures or failures.

Stage 4. The drug is found to yield a higher percentage of good results than a former remedy; it is adopted for treatment of that particular disease, and takes its place in our armamentarium; or its total worthlessness is established, and it is abandoned.

It is obvious that the element of time is neces-

sary to put a new drug in the place we want it, namely, stage 4. An understanding of the reasons for the first three stages will not eliminate them, but it will shorten the time element. Let us, therefore, look into these reasons and eliminate those elements which we, as physicians, can control.

The reasons for stage 1 have changed in recent years. Thirty years ago "new remedies" were frowned upon by the public and, to some extent, by physicians who yielded to the desire to maintain the status quo, either from mental laziness, from circumstances which prevented postgraduate study, or from financial reasons due to the attitude of their clientele.

The remark was frequently heard, especially in rural districts, "Oh, that young doctor is full of new-fangled ideas. The way grandma treated pneumonia is good enough for me! Old Doc Jones don't need to do all them tests and use a microscope to find out what's wrong with you. He can smell diphtheria and tell just by looking at a person what his trouble is." The scientifically-trained physician had a hard time, and his microscope lost him many patients. Even insistence upon a good light when delivering a baby cost him patients. I know.

Gradually that psychology changed to at least acceptance of newer discoveries and drugs. Came the New Deal, and opinion swung violently from acceptance to demand. "New" was represented as synonymous with "better," and some foolish things were done. There was a stampede to replace the "bad and outmoded" with something "new and better," and the good elements were abandoned with the bad. This applied not only to medicine, but also to government, religion and customs. Extremes usually are unwise. No good poker player discards a pair of aces to draw five cards. No, he holds the aces and tries to better them.

But the "New," and consequently "Better," psychology involved the emotions. The "New," representing security, assumed the proportions of a Shangri-La.

Think for a moment of that idea as applied to

stage 1. Ballyhoo, extravagant claims, "the wonder drug," "prominent physician reports new germ-killer"—taken all together, these postulations account for the widespread use of a new drug. The proponents of the new drug rarely make such claims, but other agencies quickly seize it, each adding its bit. Preliminary reports are too frequently taken as final, and the press, the radio, commercial interests (such as detail men, retailers and jobbers) increase the enthusiasm. Mistakes? Certainly, but often honest mistakes. Physicians who are not constantly on the watch for functional complaints, or who do not have facilities to take into account other factors, may honestly be misled by their observations, and give the drug credit it does not deserve. This is a powerful force in causing its widespread use and misuse.

Unless the exact nature of a disease is known, such errors will occur. For example, the sulfonamide drugs and penicillin do kill or inhibit the growth of certain bacteria. An asthmatic may have such an infection. The sum total of his allergy plus the infection brings on an acute spell of asthma. A sulfonamide drug or penicillin is given. The acute spell disappears, and the particular sulfonamide or penicillin is said to have "stopped the asthma." And so every asthmatic patient is given a sulfonamide or penicillin. In certain cases uncomplicated by infection the patient receives no benefit, and as a result of limited observations the administration of these drugs is stopped, not only in the uncomplicated cases but also in cases involving infection.

Asthmatic patients have remissions; some are explainable, others are not. Too often new drugs given just before such a remission are credited, in stage 1, with results they did not accomplish.

This security idea engendered by the aforementioned agencies causes a temporary cessation of many neurotic manifestations. At least 10 patients with nervous indigestion reported to me that they were "cured" by sulfanilamide. It is obvious why the first reports on the use of a new drug are largely on the favorable side.

Stage 2 is characterized, as previously stated, by reports of more scientific investigation. Secondary factors are ruled out, functional complaints are properly classified, and the percentage of favorable results drops sharply. Side effects of the new drug are reported. Some are so severe that, at this point, the drug is abandoned.

In stage 3, as a result of the reports during

stage 2, the use of the new drug is limited by physicians to one or two related conditions. As a result of the reported side effects, public opinion reverts from enthusiasm and the security idea to actual fear. More and more reports of side effects—mostly fear reactions—are noted, and physicians find it difficult to get any patient to take the drug.

Gradually the fear lessens, side effects are clarified, and the drug is stopped short of the danger point in those patients who react unfavorably. This drug then passes into stage 4, where it belongs.

Let us take one recent drug discovery and follow it as an example through its four stages: the sulfonamide drugs.

Stage 1. "The Wonder Drug will kill all germs." "Physicians no longer fear pneumonia." The demand for and use of the sulfonamide drugs were tremendous.

Stage 2. Some patients with pneumonia died in spite of sulfonamide therapy. Reports indicated it inhibited or killed only certain strains of staphylococci or streptococci. Side effects, such as a dangerous change in blood count, rashes and deaths from incompatible mixtures, appeared in the medical and lay literature.

Stage 3. Caution and overcaution became the watchwords. Many functional reactions were erroneously classed as physical reactions. Many patients refused to take the drug. Physicians selected their cases for treatment with drugs of the sulfonamide group with more knowledge and care.

Stage 4. The sulfonamide drugs are now used almost entirely in cases in which known or suspected infection caused by most of the gram-positive and gram-negative cocci and the colon bacillus group is present.

In my own work—allergy—I could go on at length tracing this or that remedy through these stages. Hydrochloric acid intravenously; potassium chloride; huge doses of vitamin C for hay fever, all now in stage 4. Benadryl is still in the concluding phase of stage 2.

Concluding Observations

What can we physicians do toward reducing the time element involved in proving the actual value of these new remedies and treatments? Recognize our limitations in stage 1. Try not to add to the hysteria by voicing unproved conclusions. Look up the rating of the physician, phar-

maceutic house or magazine publishing first reports. Bear in mind that reliable agencies maintain their good reputation by employing top notch editors, or, in the case of pharmaceutic houses, by employing competent investigators with adequate scientific facilities. They must foster that reputation and while they may make honest mistakes, they certainly try not to do so. Reports from big clinics are more likely to give a correct picture than we, with our limited observations, can give. And finally, we have an unbiased bureau supported by the doctors whose sole business it is to investigate and give a scientific answer to these problems. That agency is the Council on Pharmacy and Chemistry of the American Medical Association.

All this does not mean that we should not employ new drugs. When the explanation of their

physiologic action leads to a reasonable assumption that the effect could be as good as claimed, it seems perfectly justifiable to proceed cautiously. But remember always that apparent results do not necessarily mean that the drug in question was responsible for the improvement. Eliminate all complicating factors which can be discovered before arriving at a conclusion as to the action on the condition in question. Then wait for the reports of agencies equipped to deal with the factors the average physician cannot control or find. A conclusion reached after all or most of this evidence is in will probably be close to the correct one.

A brief glance at the "miracle drugs" of the past should convince anyone that the problem is not as simple as it appears to the layman.

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ABSTRACTS OF MEDICAL ARTICLES

TRUE HERMAPHRODITISM; ENDOCRINE STUDIES IN A CASE OF OVOTESTIS. By John C. Weed, M.D., Albert Segaloff, M.D., W. B. Wiener, M.D., and J. W. Douglas, M.D. J. Clin. Endocrinol. 7:741-748 (Nov.) 1947.

A case of true hermaphroditism with an ovotestis on the right and an ovary on the left is presented, in which there were manifestations of normal female sexual development with superimposed facial hirsutism and an enlarged clitoris. There was complete absence of the vagina. The ovotestis was found in a hernial sac, as was true in 14 cases collected from the literature. Reduction postoperatively of the 17-kelosteroid excretion suggested bioactivity in the testicular portion. The gonadotropic excretion in the urine was elevated indicating gonadal failure.

PRIMARY HYPERTROPHY AND HYPERPLASIA OF THE PARATHYROID GLANDS AS A CAUSE OF HYPERPARATHYROIDISM. By H. Milton Rogers, M.D., and F. Raymond Keating, Jr., M.D. Am. J. Med. 3:384-401 (Oct.) 1947.

The morphologic and clinical aspects of 22 cases of primary hyperplasia of the parathyroid gland collected from the literature and 4 additional cases observed at the Mayo Clinic are reviewed. It is pointed out that primary hyperplasia, a distinct clinical entity, must be differentiated from

parathyroid adenoma composed of clear cells, from metastatic renal cell carcinoma to the thyroid and from secondary parathyroid hyperplasia.

The question of hypertrophy versus hyperplasia is discussed; evidence is given for assuming that both are present but that the latter predominates. The clinical implications of primary hyperplasia are discussed. In 21 of 26 patients primary hyperplasia was accompanied by primary hyperparathyroidism. The conclusion is that this condition probably always represents primary parathyroid hyperfunction.

MISTAKEN SURGICAL DIAGNOSES IN HOOKWORM DISEASE. By Duncan McEwan, M.D., James G. Economon, M.D., and Robert E. Zellner, M.D. South. Surgeon 13:760-766 (Oct.) 1947.

A series of 46 cases is reported in which hookworm disease caused symptoms sufficiently severe to warrant hospitalization of the patients at Orange General Hospital, Orlando, over a period of seven years. In 23 of these cases abdominal symptoms were present, and in 12, the patient was admitted to the surgical service. The disease most commonly simulated was acute appendicitis.

From the data obtained, the authors conclude that the surgeon should be aware of the possibility of hookworm infestation producing abdominal

symptoms simulating appendicitis, peptic ulcer, and other diseases of the abdomen which may require surgical therapy.



SLIPPED EPIPHYSIS IN THE ADOLESCENT HIP: A RECONSIDERATION OF OPEN REDUCTION. By Paul H. Martin, M.D. J. Bone & Joint Surg. 30-A: 9-19 (Jan.) 1948.

Observation and treatment by various methods of 26 cases of slipping of the capital epiphysis (33 hips) led the author to certain conclusions concerning the probable cause of many unsatisfactory results in such cases and to the development of a therapeutic technic believed to avoid some of the pitfalls of the past through meticulous respect for the remaining blood supply of the epiphysis. These conclusions follow:

Most poor results are caused by improper treatment, and are due chiefly to avascular necrosis in the epiphysis.

Necrosis in the epiphysis is caused by further damage to its blood supply through the ligamentum teres and the periosteum on the posterior and inferior aspects of the neck.

Manipulation should be condemned except in acute traumatic cases, and it should be gentle. If reduction is not easy, closed methods should be abandoned.

Patients in the so-called preslipping stage and those with minimal slipping (less than one centimeter) are best treated by nailing in situ without reduction.

When displacement is more than one centimeter, and is gradual or has existed longer than two weeks, open reduction should be done without preliminary manipulation. This must be accomplished with due respect for the blood supply of the epiphysis. A new operative technic is described for cases of this type.

In old united cases, if there is a good hip joint, intertrochanteric osteotomy may be beneficial. Later in life, arthroplasty offers much improvement for the old arthritic hips and especially for the cases with ankylosis.



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2:30 p.m.

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Palatka, Wednesday, Oct. 26, 1949

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Ft. Lauderdale, Friday, Oct. 28, 1949

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The "Something for Nothing" Boomerang

Long a laggard in adopting the "social" point of view, at least in the opinion of social reformers who cited leaders like the Continental countries and Great Britain, Uncle Sam may well find that this seeming misfortune is turning out to be a blessing in disguise—far more of a lucky break, in fact, than many well meaning citizens of this country even now realize. A look at the race for a managed economy and a managed society should cause Americans to be well content to make haste slowly by continuing to flounder far in the rear of the socialization parade.

Those who regard a national compulsory health plan as a benefit to all and sure to come sooner or later continually cite Britain for proof. Chancellor of the Exchequer Sir Stafford Cripps in his budget speech in the spring gave interesting sidelights on British experience. He stated that last year Britain's "enjoyed an unexampled national dividend in the form of a free National Health Service at the cost, for nine months of its duration, of two hundred and eight million pounds,"—free to the individual, that is, he was obliged to explain—and he estimated the cost for the twelve months of this year at two hundred and sixty-eight million pounds. With total taxation, local and national, at a level of more than 40 per cent of the national income, inevitably the people were paying for what they received, although they had been sold on the idea that it was free. The government was finding it hard to convince the voter that the service is not free at all. How to show him that he could not just barge into a doctor's office and order every-

thing in sight was the problem. "There was, indeed, a very good argument," said Sir Stafford, "for imposing some special charge or tax in connection with the health services, both to help finance them and to bring home to the people generally the simple fact that they had to be paid for out of taxation." But before resorting to a price tag, he concluded, it would be well to await the outcome of another year. Presumably, by then another election would be history.

The "something for nothing" attitude is proving a difficult and dangerous boomerang to Britain's Socialist Government as it now wallows deeper and deeper in financial troubles. The Socialist leaders, who once encouraged this attitude among wage earners, now find it next to impossible to turn the idea aside. Frankly worried about worker indifference to Socialist problems as they struggle to get more work done for the money in an effort to solve financial woes, they are confronted with demands for less, not more, work and more, not fewer, benefits. This worry was recently expressed by Aneurin Bevan, director of Britain's socialized medicine program, in these words: "Some of our people have got what they got too easily, and they are in danger of throwing away by a few months of anarchy what we have spent our lifetime in building up."

Many workers find themselves better off now in Britain's time of poverty than in the days of relative prosperity before the war, and naturally what they want is more of the good things of life regard-

less of the government's financial problems with the rest of the world. The Labor Government, aided by American dollars, has carefully shielded workingmen generally from the full impact of the country's hard times. Their wages are up; food costs have been held down through subsidies; there is much more social security. Grumbling at attempts to put a ceiling on wages was quieted when fresh "something for nothing" benefits came along in the form of socialized medicine. Now that the Labor regime may have to crack down on its rank and file supporters or watch Britain's remaining dollar resources drain away, the problem is how to adjust to a lower, not higher, standard of living and at the same time avoid political upheaval. Its leaders are finding themselves enmeshed in a web of their own weaving—disastrous "something for nothing" propaganda.

History teaches that social legislation, once enacted, is rarely reversible. In the concluding paragraph of an editorial, aptly titled "England Finds Free Ride Ain't Necessarily So," in the July 16 issue of the *Saturday Evening Post* there is an admonition which every American, and particularly the present administration, may well heed: "A good deal of the Labor Party's legislation in the last four years amounted to action as irreversible as going over Niagara Falls in a barrel. The Health Plan, no matter how unwisely framed, is now considered politically untouchable. Before we get involved in any similar efforts, it may pay us to kibitz for a while." It appears that Uncle Sam would do well to continue to flounder in the rereward of so-called social progress leading to the welfare state and at the same time remain in the vanguard of free enterprise.

British Opinions on Socialization of Medicine

A prominent American industrialist whose company has factories in England returned in July from an extended business trip there and summarized his impressions of socialized medicine at work in Britain. His many and varied contacts make his observations of particular interest at this time when that country's present financial difficulties are being blamed more and more on the Labor Government's improvident program of social benefits.

This friend related that persons who rarely in the past had had the opportunity to contact doctors regard socialized medicine as a wonderful

benefit. Social betterment enthusiasts of course view it as an excellent forward step. The young doctors, too, who immediately obtain a very satisfactory income without being obliged to build up a reputation, favor it.

On the other hand, many with established contacts over the years have found that they cannot see their doctors at all, or their doctors are so tired out when they do see them that they do not have the special contacts that they have had before. Two cousins of this observer, aged 82 and 90, found themselves completely cut off from their family doctor and assigned to a young doctor who, they felt, took no interest whatever in them. The socialized plan is, therefore, especially unpopular with the older middle class.

The plan appears to be not only of no benefit but actually a detriment to the specialists. Many of them have preferred to depend on their old clientele rather than affiliate with the new scheme.

With the government providing medicines and supplies free on order of a physician, there is inevitably great waste. Much of the time of the doctors during office hours is spent writing prescriptions for miscellaneous common remedies formerly purchased from time to time as needed. Many hospitals are being closed because of lack of sufficient staff to operate them and because of rates necessarily conflicting with government rates.

An instance personally noted was the case of a boy needing glasses badly, who had to wait six months to get them and then broke them the next day. The family was having difficulty ascertaining how to go about having the glasses replaced, and the belief was that the child would have to wait another six months.

The general tendency is an acquiescence on the part of most English people to socialized conditions. There is, however, widespread opinion that socialized medicine had not been studied sufficiently before being adopted in Britain, and as a result it is "a terrifically confused mess," which may or may not straighten out to the proper advantage of those it is intended to serve.

One industrialist heading a very large company stated that socialized medicine in industry, in effect there since 1910, had worked successfully owing to the supervision given by the individual companies, but with national socialization and expansion, the red tape involved in government procedures has prevented it from working out nearly as satisfactorily, and the cost has far exceeded estimates. He thought that the people of his coun-

try need better medical attention than they have had, but he did not believe that the socialized plan as now worked out is answering the problem, and he was of the opinion that the plan needs a great deal of revamping before it will perform in industry as well as it did for so many years before the government put into effect its national health scheme.

Fifth Anniversary of Florida's Blue Cross Plan: Dr. Hawley Speaks

The fifth anniversary of the birth of Florida's Blue Cross Plan for hospital care was observed on the night of July 21, 1949 with a dinner at the Roosevelt Hotel in Jacksonville.

Mr. W. E. Arnold, President of the Florida Hospital Service Corporation, presided. Dr. C. C. Hillman of Miami, President-Elect of the Florida Hospital Association, Dr. Walter C. Payne of Pensacola, President of the Florida Medical Association, and Mr. J. Edwin Larson, State Treasurer and Insurance Commissioner, made short talks, following which Mr. H. A. Schroder, Executive Director of the Florida Hospital Service Corporation and the Florida Medical Service Corporation, formally presented Mr. Ernest E. Reese with a certificate which certified that he had become the 200,000th member of Florida Blue Cross.

Dr. Paul R. Hawley of Chicago, the chief executive officer of the Blue Cross and Blue Shield Commissions, was the principal speaker of the evening. A retired Major General of the United States Army, Dr. Hawley served as chief surgeon of the European Theater of Operations during World War II and was the first chief medical director of the Veterans Administration. This brilliant leader and thinker delivered an epoch-making speech before a conference of state medical association officers in Chicago about a year ago, which was recognized and reported as such under commentaries in the November 1948 issue of *The Journal*.

Replying to a highly complimentary introduction by the presiding officer on this anniversary occasion, Dr. Hawley departed from his planned speech and immediately gained the approbation and rapt attention of his listeners. First he simply and modestly directed attention to the fact that what one does in the future is of importance, not what one has done in the past. He then told an amusing story: A farmer was leading a somewhat obstinate calf down a road. Upon reaching a

bridge the calf refused to budge, thereby blocking traffic. A motorist who drew up behind the animal offered to blow his horn to help get the calf across. The blast, however, was of such magnitude that the calf became frightened, made a wild leap, landed on the rocks below and broke his neck. The farmer accepted the motorist's apologies, but added: "That was an awfully big noise for an awfully little calf." Dr. Hawley then delivered a shrewd talk abounding in farsightedness and discernment, which convinced the audience in a very short time that the presiding officer's introductory blast had not been at all too big.

The address merits reproduction here in its entirety:

I was delighted to receive an invitation to join with you in this celebration of your Fifth Anniversary, and to bring to you the heartiest congratulations both of the Blue Cross Commission and of its staff. There are many characteristics of this Plan which endear it to me.

First, its rapid and healthy growth. To have passed the 200,000 mark and to have enrolled more than 8½ per cent of the population of Florida within such a short time is an achievement of which all Blue Cross can be proud. Furthermore, the data, which we have in the Commission office, indicates that the rate of growth of this Plan is accelerating all the time.

Second, your joint operation with Blue Shield is a great source of satisfaction to us who are trying to offer to the public protection against the cost of illness in one package. The afflicted family does not break down the cost of sickness into what goes to the doctor and what goes to the hospital. It all comes out of one place—the family bank account—and Blue Cross and Blue Shield are not protecting the incomes of hospitals and doctors, but are protecting the family bank accounts. It would be absurd to offer fire insurance in several packages—one indemnifying the damage to carpenter work, another the damage to plumbing, and still another the damage to electrical wiring. It is equally absurd to offer to the public protection against the cost of illness in more than one package, regardless of what type of organization or organizations do the actual underwriting.

Third, Florida Hospital Service Corporation endeared itself, together with Florida Medical Service Corporation, to all Blue Cross and Blue Shield by their generous hospitality during the last Conference of Plans. This was a memorable

conference, not only because of the forward steps there taken but also for the pleasant surroundings that were fully enjoyed by all in attendance.

Lastly, although I regret to make him blush, the contributions of your Executive Director to the national movement of both Blue Cross and Blue Shield have marked him as a leader in our field; and his great capacity for friendship is not among the least of his assets.

The situation as regards health legislation is very like one of your famous hurricanes. There was a considerable wind for some months, which died down abruptly when the proponents of compulsory health insurance became convinced that passage of the Thomas-Murray-Dingell Bill in the present session of Congress was an impossibility.

There is grave danger that some of us may think that the storm has passed. No one who has experienced a Florida hurricane would be so deceived. It is only that the center of the disturbance is now passing over; and, once it has passed, we may be certain that the storm will be renewed, perhaps with increased fury for the reason that there is a possibility that the political complexion of the Congress will change at the end of the next session, which will offer some respite from the danger of socialistic legislation.

Some six weeks ago, I appeared before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. Senator Murray presided, and with him as a proponent of compulsory health insurance was Senator Pepper. The opponents were represented by Senators Taft and Donnell.

I am certain that my testimony changed no views in that subcommittee; but there was a lively period of questions and answers in which was revealed some unique thinking. First, the inevitable question was asked me: "What is your definition of 'socialized medicine?'"

This is a very pertinent question—particularly so since the proponents of compulsory health insurance have now adopted it to denounce all voluntary health plans proposed to the Congress. This is very amusing; it reminds one of those painful experiences in childhood wherein some nimbewitted playmate hurled a biting epithet in one's teeth, to which the only retort that could be produced in the confusion of the moment was, "You're another." I am surprised, but rather pleased, that the only epithet the proponents of compulsory health insurance can devise for voluntary plans is to call them "socialized medicine."

However—to define "socialized medicine." The first step is to say that "socialized medicine" is that pattern of medical care which is fashioned upon socialistic principles; and then we must define the principles of socialism.

I am astonished to find the great number of people who think that "government medicine" and "socialized medicine" are one and the same thing. As a matter of fact, little, if any, of the medicine now practiced by the Federal Government—and there is lots of it—is "socialized medicine." The medical care given the Armed Forces is not socialized medicine—it is a part of their compensation. It is no more socialism than is the manse furnished a minister of the Gospel socialized housing. The medical care given the veteran with a nonservice-connected disability is "free medical care," and is no more socialized than a bonus or a pension. The medical care given the service-connected disabilities of veterans is a part of the liability the Government assumed in using their services—an employer's liability.

Do not confuse such medical care with "socialized medicine," or accept the argument that already some 20 or 30 million Americans have "socialized medicine." There is a vast difference. It may be that we should fight further extension of government medicine, but we shall then be fighting an entirely different thing.

The essential element of socialist philosophy—and almost the only one upon which all political historians would agree—is that all the world's goods be distributed "to each according to his needs," without regard to the productivity of the individual or to his contribution to the social organization. Thus every citizen should share alike in goods and services, it matters not whether he is able and industrious or incapable and slothful.

While Socialists seek common ownership and collective control of the means of production and exchange of all goods and services, this does not necessarily involve nationalization of industries or services. In fact, there were numerous Socialist colonies established in the 19th Century, which were voluntary organizations of individual citizens pledged to this basic principle.

Every one of these voluntary Socialist experiments failed! None survived more than a few years. And why?

They all failed because the able and industrious tired of supporting the lazy and the irresponsible. When the able ones left the colony, the others were unable to support themselves.

This is why Socialism can succeed only when enforced by government. There must be the element of compulsion which forces the thrifty and the industrious to give up a large part of their earnings to support the wilfully unproductive. Voluntary philanthropy is one thing, and has relieved much suffering in this world. Heavy taxation has largely dried up the sources of voluntary philanthropy; and now we are fast developing a political philosophy that it is the divine right of every citizen to share fully in luxuries as well as in necessities, regardless of whether or not he ever does a truly honest day's work.

The Thomas-Murray-Dingell Bill is socialistic because it distributes equal benefits but collects unequal contributions. Mr. Ewing calls this the same kind of insurance that has been a part of our national fabric for generations. There is no one present but who knows, first, that no insurance has ever operated upon this principle until so-called social insurance was devised; and, second, that the only people who would ever purchase such insurance voluntarily would be those able to get it at the break-even point or below. Can you imagine anyone voluntarily paying any more for his protection than the protection is worth—just so that someone else can purchase it cheaper? Could you sell automobiles or refrigerators or radios on this principle?

Yet this is exactly what the latest health bill introduced in the Congress—the Ives Bill—proposes to do. It proposes to encourage all voluntary prepayment health plans which will scale their rates in accordance with income of subscribers. It proposes to subsidize voluntary plans which agree to do this.

In the first place, this Bill is just as socialistic as the Thomas-Murray-Dingell Bill. Remember that insurance does not need to be nationalized or compulsory to be socialistic. Social insurance of all kinds has to be compulsory in order to sell it, but it is not socialistic because it is compulsory.

The Ives Bill is silent upon the rates to be charged. Where, then, would the break-even rate be placed—in what income group? Suppose the break-even point were placed at the \$3,000 income level. Would people with incomes of \$5,000 or \$6,000 voluntarily pay that much more for their protection than it was worth, or would they turn to commercial carriers who would offer them straight indemnity at somewhere near its value?

Suppose the break-even rate were placed at the high income level. Then the amount of subsidy

required for all other coverage would make the cost prohibitive.

The motives of the sponsors of the Ives Bill are beyond suspicion. They are honest and earnest American citizens, who are bitterly opposed to compulsory health insurance. They are intelligent men, which makes it hard to understand how they have been deluded into thinking, first, that this is a workable measure, and, second, that so revolutionary a measure as this is all that will defeat the Thomas-Murray-Dingell Bill. Because of the unquestioned sincerity and integrity of the sponsors of this legislation, I regret deeply that Blue Cross must oppose it. This is another example of the truth which states that friends often can be more dangerous than enemies.

It is not very convincing to condemn the Thomas-Murray-Dingell Bill merely because it is socialistic. We already have socialistic legislation in the books. The question is, how far do we want to go toward the Welfare State?

Compulsory health insurance is the longest leap yet proposed; and, once it is taken, the question will no longer be whether we want to have a Welfare State—we shall already have it. Other measures will follow in rapid order once this great leap is taken; and, before we realize it, we shall have a State like that in Great Britain.

Do we want this? What, in Heaven, is there today in Great Britain that we can possibly envy? A lower standard of living. A hungry people. Government regimentation of currency, housing, food, recreation. A country on the verge of bankruptcy—and brought to this critical juncture largely, in the words of their own Chancellor of the Exchequer, through the cost of their social insurance scheme.

It is difficult to conceive how any intelligent American can look at Great Britain and advocate a similar program in the United States. I say this is difficult—yet it is not now so difficult for me after my experience upon the witness stand of the Senate Subcommittee on Health. In one exchange of questions and answers, I stated that adequate protection against the cost of serious acute illness for an entire family could be purchased for the price of one package of cigarettes a day; whereupon a Senator asked me, in effect, if I expected people to give up smoking in order to have medical care—whether I expected them to forego part of the movies they attend regularly in order to provide good medical care for their families.

He went on to say that voluntary prepayment plans would never do the job because too many people would not subscribe—that you had to compel people to carry health insurance, else too many would not do it.

There you have it, my friends. We have influential people in Congress who profess openly to believe that people should be encouraged to spend their earnings first for luxuries; and, if there be not enough left for necessities, the taxpayer will provide them.

We have influential people in Congress who state openly that no longer should American citizens be privileged to decide for themselves whether or not they will carry insurance—they must be compelled to carry it.

The direction in which this Administration is headed is clearly charted by such statements. If this is the kind of America that you want, you should give full support to this Welfare State program. If it isn't the kind of America you want, you had better fight, fight hard, and keep on fighting—or you will have that kind of America whether you want it or not.

American Heart Association Research Awards

A quarter of a million dollars has been allocated by the American Heart Association for studies in cardiac and circulatory disease. One hundred and twenty-one requests, all of high caliber and deserving of fulfillment, totaled almost a million and a half dollars. These requests indicate the tremendous medical interest in finding solutions for problems in the cardiovascular field and also the pressing need for research funds to increase knowledge of the causes of diseases of the heart and blood vessels.

In line with a policy of supporting younger scientists in the field of medical research to develop investigators in cardiovascular disease, \$103,800 was allocated to twenty-five research fellowships, the individual stipends ranging from \$3,000 to \$4,000 to cover one year periods beginning, in most instances, on July 1, 1949. Three of these fellowships were made available in Southern institutions. Cerebral blood flow will be studied at Duke University School of Medicine, physiology at Tulane University School of Medicine, and hypertension at Southwestern Medical College.

Dr. W. Mommaerts of Duke University, one of

two established investigators engaged in independent research who were given aid, received a grant for continuation of research in the biochemistry of muscular contraction. Of six grants-in-aid, one was an award of \$25,000 to Dr. Albert Szent Gyorgyi for research on muscular contraction, and five went to institutions for cardiovascular studies. Additional funds were also provided for basic research and cooperative research studies.

Diabetes Detection Drive Progresses

The diabetes detection drive inaugurated by the American Diabetes Association during Diabetes Week last December covered 145,960 patients, including 37,243 children. In announcing these figures, Dr. Howard F. Root of Boston stated that the program is continuing and the results are not yet complete.

It is noteworthy that no money was sought from the public during the drive. Local committees of physicians from county medical societies made provision for free testing of urine of patients either in physicians' offices or in detection centers. To say the least, this attempt by American physicians to attack a public health problem without asking for money is certainly a good will gesture.

Recent studies highlight the importance of this work. They indicate that there may be as many as two million diabetics in the United States, at least half of whom are unaware of their illness. Diabetes Week this year will be observed from October 10 to 16.

Health Legislation Before the Eighty-First Congress

At this writing the first session of the Eighty-First Congress is rapidly drawing to a close. Although extending the period beyond the normal terminating date of July 31, the date of adjournment has been inferred as at a time near Labor Day. During this first session the quantity of proposed legislation dealing directly or indirectly with public health has been voluminous. Of primary concern to the medical profession have been measures containing provisions for some form of compulsory health insurance. Present indications are that legislation of this type is unlikely to be considered at this session, but will continue to be a major issue in 1951.

Perhaps the most familiar to the general public is the Administration-approved Thomas-Murray-Wagner bill. This is a so-called omnibus bill

based on the recommendations of Federal Security Administrator Oscar Ewing in his report to the President entitled, "The Nation's Health," and which contains a comprehensive program for compulsory health insurance. The equally well known name of Dingell, associated with such proposals in the past, may be found on an identical bill introduced by him into the House of Representatives.

Other significant measures introduced into the Senate include the Taft bill, the Hill bill and the Flanders-Ives bill. Companion or similar proposals may be found in the House of Representatives. All three are characterized by grants-in-aid to the several states for the purpose of establishing or expanding already existing health facilities. The Taft bill would coordinate the health functions of the federal government in a single agency. Both the Hill and Flanders-Ives bills stress assistance to voluntary prepayment health plans to provide for more extensive coverage to everyone, regardless of economic status.

Some Senators and Congressmen have said that they seldom hear from their doctors on proposed health legislation, either at the Capitol or at home. One Florida Congressman has stated that he considers medical men ambiguous in their requests. As these men visit in their home communities and throughout the state following adjournment of the Congress, physicians will have opportunity to make it impossible for a Senator or Representative from this state to make such charges of neglect, and an equally excellent chance to eliminate any ambiguity which may exist.

YOUR BLUE SHIELD

A.M.A. House of Delegates Approves Separation of A.M.A. and A.M.C.P.

Complete separation of the American Medical Association and the Associated Medical Care Plans (Blue Shield) was approved by the A.M.A. House of Delegates at its Ninety-Eighth Annual Session in Atlantic City, meeting from June 6 to 9, 1949.

Recommended originally by the Council on Medical Service of the A.M.A. in a statement delivered to the Blue Shield Commission of A.M.C.P. at its meeting in Hollywood, on April 15, 1949, the separation was accepted by the Blue Shield national organization before the question was placed before the A.M.A. House of Delegates.

E. Vincent Askey, M.D. (California), chairman of the reference committee to which the

Council's recommendation was referred, in commenting on the committee's report said, "Your reference committee feels that it is important that the Delegates read carefully the comment of the Council on Medical Service, appearing in the second paragraph of its recommendation, so there may be no misunderstanding as to the value attached to the accomplishments of A.M.C.P."

The statement referred to in Dr. Askey's word of caution said, "The Council on Medical Service desires at this time to acknowledge the efforts of A.M.C.P. in promoting through its member plans the principle of voluntary prepayment health insurance; and believes that A.M.C.P. has reached a state of development where it can function more adequately as an autonomous trade association."

In approving another resolution, introduced by L. Howard Schriver, M.D. (Ohio), the House of Delegates pledged its support to A.M.C.P. as an independent federated agency representing state and local Blue Shield Plans.

It was commonly agreed, by all concerned, that one of the reasons for the separation of these two organizations had been an inability to agree upon a Blue Shield proposal to establish a national enrolment agency for handling so-called national accounts. The dilemma was bridged by adoption of the Schriver resolution, which "resolved, That the several state and local Blue Shield Plans continue the development of an enrolment agency to act in their interest in the field of so-called 'national accounts,' using their best judgment (and that of sponsoring societies) with respect to the methods, means, procedure and form or organization by which the problems related to national accounts may be solved."

Five members of the Blue Shield Commission originally appointed by the Council on Medical Service were invited by the commission to continue their membership as individuals, even though they no longer represented the A.M.A. The five commissioners include Drs. A. W. Adson, Elmer Hess, Charles Gordon Heyd, J. D. McCarthy and Carl F. Vohs.

Leaders in the Blue Shield movement accepted the change in status as an indication that A.M.C.P. had matured to the point where it could function efficiently as an independent trade organization, and without official relationship to the A.M.A. A situation which had become highly controversial was resolved to the apparent satisfaction of everyone involved. The Florida Blue Shield Plan was unanimously in accord with this decision.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

F. Gordon King of Jacksonville, local Edward C. DeSausure Post 9, American Legion

Kenneth Dunham of Frostproof, Lake Wales Rotary Club

James R. Boulware, Jr., of Lakeland, local Kiwanis Club

Walter C. Payne of Pensacola, local Kiwanis Club

Francis T. Holland of Tallahassee, local Kiwanis Club

James R. Boulware, Jr., of Lakeland, Bartow Kiwanis Club

James E. Thompson of Tarpon Springs, local Lion's Club

Francis T. Holland of Tallahassee, Woman's Auxiliary to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

Edward R. Annis of Miami, local Exchange Club

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Joseph B. Pomerance of Miami Beach announce the birth of a son on May 3, 1949.

Dr. and Mrs. Francis C. Skilling of Miami announce the birth of a daughter, Mary Emma, on June 10, 1949.

Marriages

Dr. Floyd L. Pichler and Miss Ruby Virginia Hicks of Jacksonville were married on June 30, 1949

Dr. Martin S. Belle of Miami and Miss Marylyn Rita Horowitz were married on April 29, 1949

Deaths—Members

Dr. Rayburn N. Joyner, Marianna July 9, 1949

Dr. Major E. Threlkeld, Miami July 12, 1949

Dr. Frederick L. Flynn, St. Petersburg July 12, 1949

Dr. Thomas A. Neal, Orlando June 22, 1949

Dr. C. Larimore Perry, Miami July 6, 1949

Dr. Nilo C. Pintado, Miami June 11, 1949

Dr. Luther A. Hodsdon, Miami July 9, 1949

Deaths—Other Doctors

Dr. Victor P. Genge, Fort Walton July, 1949

Dr. Siver A. Wilson, Bradenton July 2, 1948

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STATE NEWS ITEMS

Florida members have paid 81 per cent of the assessment levied for the National Education Campaign by the A.M.A. Those members who have not already done so are urged to rush \$25.00 to the secretaries of their county medical societies. Secretaries will promptly forward assessments to the Florida Medical Association, Jacksonville. Florida is among the states that are in the lead. Act now and push Florida's record to the top.

Any member desiring to read a paper at one of the Scientific Assemblies at the 1950 annual meeting in Hollywood is requested to communicate with Dr. Frederick K. Herpel, 223 Sunset Road, West Palm Beach, chairman of the Association's Committee on Scientific Work.

Dr. Herpel urges that any member making application submit a copy of his paper or a fifty word synopsis.

All applications must be received by Dr. Herpel on or before November 15 to permit time for arranging a well balanced program.

Dr. Robert B. McIver of Jacksonville and Dr. Herbert L. Bryans of Pensacola have been reappointed to the Florida State Board of Health for four year terms by Governor Warren.

Drs. William L. Wagener, Jr., and Glenn H. Heller of Coral Gables have returned to their practices after attending a course in surgical anatomy at Cornell Medical College. Dr. Heller also attended a course in surgical technic at the Cook County Graduate School of Medicine in Chicago.

Dr. A. Denton Jones of Jacksonville is at the Crile Clinic in Cleveland studying the ear, nose and throat. Dr. Jones received a fellowship.

Dr. Raymond L. Evans of Miami has returned to his practice after taking a postgraduate course in surgery at the Mayo Clinic.

Dr. Ashbel C. Williams of Jacksonville attended several surgical clinics in Boston in June.

Dr. Miles A. Collier of Wauchula flew to Mexico City, Mexico, in July to attend a medical meeting, visit clinics and hospitals and study tropical diseases.

Dr. Carl M. Pults of Lake Worth spent the month of July in Boston where he received a postgraduate course in heart diseases at the Harvard Medical School.

Dr. Paul L. Berezney of St. Petersburg has accepted a position as resident surgeon at the Mercy Hospital in Hamilton, Ohio. After completing the four year study in advanced surgery, Dr. Berezney plans to return to St. Petersburg to continue his practice.

Dr. Howard G. Holland of Leesburg and Dr. Carl D. Hoffman of Orlando attended the International Conference of Gynecologists in London in July. They also visited hospitals and clinics in Paris and Marseilles.

Dr. J. Powell Adams of Panama City has accepted the position as a resident in radiology at the Woodlawn Hospital in Chicago, where he will spend a year in the study of radiology.

Dr. Gerard E. Christie of Titusville took a postgraduate course at Columbia University in July.

Dr. Henry L. Smith, Jr., formerly of Jacksonville, has opened offices for the practice of urology in Tallahassee.

Dr. Ralph N. Greene, Jr., of Jacksonville recently addressed the Southside Lions Club on "The Eyes As a Barometer of the Body's Health."

Dr. Walker Stamps of Jacksonville recently was appointed by Governor Warren to the Duval County Welfare Board to take the place of Dr. Webster Merritt, Jacksonville.

Drs. Russell B. Carson of Ft. Lauderdale, James J. Nugent of Miami and Joseph C. Hayward of Orlando attended the recent annual meeting of the American Urological Association which was held in Los Angeles.

Dr. Frank A. Sica announces the removal of his office from Fellsmere and Sebastian to 628 Ridgewood Avenue, Holly Hill.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Ande, Willard F., West Palm Beach
Barrett, Bernard M., Pensacola
Bell, Alan E., Pensacola
Chapman, John F., West Palm Beach
Coppedge, Wayland T., Jacksonville
Counts, Russell L., Bránford
Foley, Joseph D., Jacksonville
Halpern, Morton M., Miami
Holland, Ned W., Tampa
Klinkenberg, Royle B., Hollywood
Lindner, John D., Ocala
Moore, John P., Ocala
Price, Morris A., Jacksonville
Rhea, Samuel B. D., Pensacola
Roy, Raymond S., West Palm Beach
Schenck, Kenneth W., Ft. Lauderdale
Tanous, John H., Miami Beach
Taylor, G. Dekle, Jacksonville
Waldrep, Jack M., Ocala
York, Dale E., Pensacola

COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Charlotte-Glades

The July meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held at the Simmons Hotel in Wauchula. Dr. Thomas M. Edwards of Tampa was the guest speaker. He discussed otosclerosis and also treatment of burns of the esophagus caused by lye.

Members present included Drs. Godfrey L. Beaumont, Isaac W. Chandler, Hubert W. Coleman, Merle C. Kayton, Charles H. Kirkpatrick, Carl J. Larsen, Leldon W. Martin, Ruth M. Miller, Edwin C. Northup, Wesley S. Pyatt, Zaven M. Seron, John A. Simmons, James G. Smith, Jr., and Stanley K. Wallace. Dr. H. W. Martin, a dentist from Sebring, was among the guests.

All members of the society have paid Association dues for 1949.

Pinellas

At the July meeting of the Pinellas County Medical Society which was held at the Detroit Hotel in St. Petersburg, Dr. Gordon B. Taylor

presented a paper entitled, "Dermatitis Due to Wearing Apparel." He was introduced by Dr. Albert R. Frederick, program chairman. Dr. Taylor's paper was discussed by Drs. Louis B. Mount, Arthur H. Reynolds and Kenneth J. Weiler.

Seminole

All members of the Seminole County Medical Society are participating physicians of the Florida Hospital Service Corporation (Blue Cross) and of the Florida Medical Service Corporation (Blue Shield).

On July 7 members of the society were guests of the Dental Society on a boat trip up the St. Johns River. They enjoyed fishing, swimming and a picnic lunch.

OBITUARIES

Spencer Augustus Folsom

Dr. Spencer A. Folsom of Orlando died suddenly of a heart attack on June 26, 1949. He was 53 years of age.

Dr. Folsom was born on Aug. 15, 1896 in San Francisco, and received his medical degree in 1917 from the Emory University School of Medicine in Atlanta. He had an outstanding record in World War I, when he served as a medical officer with the United States Marine Corps. He began the practice of medicine in Orlando in 1926 after practicing several years in Haines City.

One of the state's leading diagnosticians, this distinguished internist contributed much time and effort toward the advancement of his profession. He was a past president of the Orange County Medical Society and of the staff of the Orange Memorial Hospital, where he was chief of the medical service. As a member of the Florida Medical Association, he participated in its activities as a councilor and a member of committees. He also served as an associate editor of The Journal and was a frequent contributor to its scientific and editorial columns. He was a fellow of the American Medical Association and of the American College of Physicians.

His widow, Mrs. Mary Margaret Folsom, a son, Spencer A. Folsom, Jr., and a daughter, Miss Jean Folsom, survive him.

Rayburn Nelson Joyner

Dr. Rayburn N. Joyner of Marianna died on July 9, 1949, following a heart attack, which he suffered while in Chipley. He was 38 years of age. Interment took place in Wake Forest, N. C., where he was born.

Dr. Joyner received his medical degree from the Duke University School of Medicine in 1933. In 1935 he came to Florida to accept the position of director of the Jackson county health department. Two years later he entered private practice in Marianna. He participated in the civic and social activities of that city and was a member of the Rotary and Elks Clubs and of the First Baptist Church.

A member and former secretary of the Jackson County Medical Society, Dr. Joyner was also a member of the Florida Medical Association and of the American Medical Association.

Survivors include his widow, Mrs. Marie Joyner; two daughters, Rena Margaret and Susan; a son, Rayburn Nelson, Jr., all of Marianna; his mother, Mrs. Rena L. Joyner of Wake Forest; and two sisters, Mrs. Rena McDevitt of Wake Forest, and Mrs. Margaret Edwards of Wilmington, N. C.

Thomas Albert Neal

Dr. Thomas A. Neal of Orlando died at the Florida Sanitarium on June 22, 1949, following an illness of several weeks. He was 74 years of age.

Dr. Neal was born in Commerce, Ga., and was an honor graduate of the University of Georgia in 1899. He received his medical degree from the Atlanta College of Physicians and Surgeons in 1903. At that time he began the practice of medicine in Florida. In 1914 he entered the United States Army and served during World War I. Following his separation from the service, he located in Orlando, where he became endeared to Orlando citizens as a family physician.

He was one of the first members of the Orlando Rotary Club and had a perfect attendance record for more than twenty-seven years. Dr. Neal was a member of the Orange County Medical Society and of the staffs of the Florida Sanitarium and the Children's Home Society. He

was a life member of the Florida Medical Association and had served as an associate editor of The Journal. He also was a fellow of the American Medical Association.

Surviving are his widow, Mrs. Olive Fitts Neal; a daughter, Mrs. Edward Lyne Strehbehn of San Juan, P. R.; two grandchildren, and several nieces and nephews.

Nelson Miles Black, Jr.

Dr. Nelson M. Black, Jr., of Miami died on June 9, 1949 of an infectious disease indigenous to the Far East, where he spent several years serving as a flight surgeon with the rank of captain in the United States Army Air Forces. He was 36 years of age.

Dr. Black was born on Dec. 3, 1912, in Milwaukee, the son of Dr. and Mrs. Nelson M. Black, Sr. At the age of seventeen, he moved to Miami, where his father at the present time is specializing in ophthalmology. After receiving his Bachelor of Arts degree at Dartmouth College in 1936, he entered the University of Pennsylvania School of Medicine, from which he was graduated in 1939.

Until August 1942 when he entered the armed forces, Dr. Black served an internship and residency in ophthalmology at the University Hospital in Iowa City, Iowa. During this time he was associated with Dr. P. J. Leinfelder in a study of the *Macacus rhesus*. Following separation from the service in January 1946 and completion of a brushup course at Iowa City, in April of that year he began the practice of ophthalmology in association with his father in Miami.

Dr. Black's military career in the China-Burma-India theater and in the Marianna Islands was climaxed by his daring rescue of several crew members following the crash of a bomber loaded with ammunition. For his outstanding courage in the face of personal danger, he was awarded the Soldier's Medal.

The young physician was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He also was a member of the Alpha Mu Pi Omega medical fraternity.

In addition to his parents, survivors include his widow, Mrs. Susan Blow Black of Miami, to whom he was married in 1939.

WOMAN'S AUXILIARY

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Public Relations Chairman Speaks

Public relations is a term which disturbs many doctors. They are unable to confine it to one specific single definition which at all times covers its functions and phases. One medical society had created this unstandable definition: "The task which the medical profession has, and which it has always had, of fitting itself to the pattern of public desires has lately come to be called Public Relations."

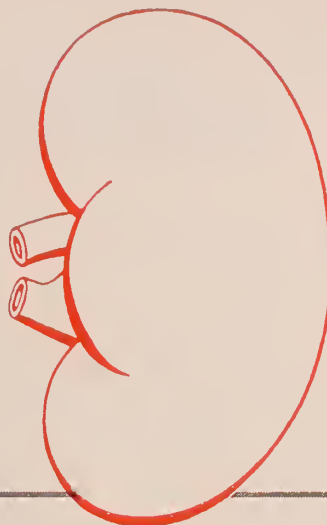
In doing auxiliary public relations work, we should remember that we are not called upon to defend the American doctor. He needs no defense. Under the free enterprise system of medical practice in this country, the American medical doctor has been the major contributing factor in producing one of the healthiest nations in the world, in addition to having attained the highest degree of scientific achievement. It is our duty to disseminate this information to the public.

Long ago the ground work for Public Relations should have been formulated. Information can be distributed by presenting health forums and radio skits, by offering programs to lay organizations, by assisting and providing doctor speakers, by training a carefully selected group of auxiliary members to speak on our state Blue Shield Plan, by bolstering our newspaper contacts, by touring rural areas with lectures, simple exhibits, films and pamphlets, by speaking before high school children, the voters of tomorrow. Get before your community health facilities and re-

(Continued on page 174)

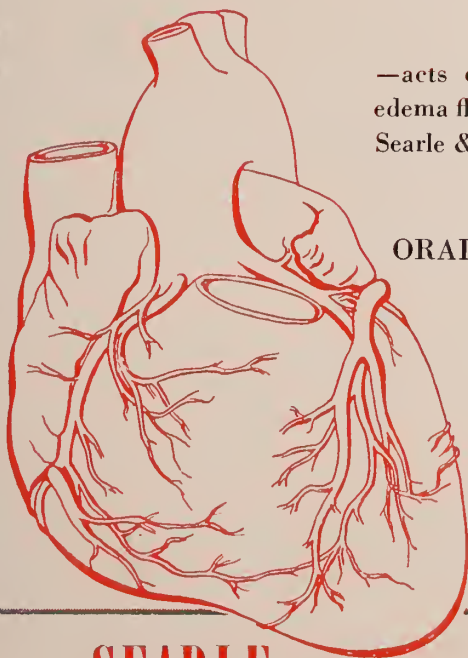
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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

1. Brown, W. E., and Bradbury, J. T.: The Effectiveness of Various Diuretic Agents in Causing Sodium Excretion in Pregnant Women, *Am. J. Obst. & Gynec.* 56:1 (July) 1948.

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member to work through health committees in lay organizations. Special attention should be given to P.-T.A., League of Women Voters, Democratic and Republican and other women's clubs, State Federation of Women's Clubs, A. A. U. W., and other organizations. With these groups, it would be well to work toward obtaining resolutions opposing compulsory health insurance.

Caution should be used in the preparation of material. For obvious reasons, it must agree with policies and established procedures of the A.M.A., our State Medical Association, and at the home level, with our county medical society. It is more important than ever that we present a united front. This cannot be accomplished if the auxiliary fails to align its material with that being used by the medical society. This can be done only if Mrs. Doe expresses the same thoughts as Dr. Doe.

Whitaker and Baxter, leaders in our National Education Campaign, suggest: "Many officials and employers of the Social Security Department and various other government agencies are taking the stump to speak for Compulsory Health Insurance. May we suggest that doctors and friends of our cause who attend meetings where Government officials are speaking for socialized medicine, ask such questions as the following: 'Who is paying you to make this appearance? Are you here at the taxpayers' expense, agency or committee?' This should be done quietly and politely. There is no need for argument. The audience will get the point, no matter what alibi the speaker may trot out."

Will you please put me on your mailing list? If you have any suggestions, criticisms, or aid to offer, please feel free to pass them along to your State Public Relations Committee.

Sincerely yours

Mrs. Herschel G. Cole

State Chairman of Public Relations

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GYNECOLOGY—Intensive Course, Two Weeks, starting September 26, October 24.

Vaginal Approach to Pelvic Surgery, One Week, starting September 19, November 7.

OBSTETRICS—Intensive Course, Two Weeks, starting September 12, November 7.

MEDICINE—Intensive General Course, Two Weeks, starting October 3.

Gastroenterology, Two Weeks, starting October 24.

Gastroscopy, Two Weeks, starting September 26, October 24.

DERMATOLOGY—Formal Course, Two Weeks, starting October 24. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic & Lecture Course First Monday of every month.

Clinical Course Third Monday of every month. X-Ray Therapy every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 26. Ten Day Practical Course in Cystoscopy every two weeks.

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BOOKS RECEIVED

NEW AND NONOFFICIAL REMEDIES, 1949. Issued under the Direction and Supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Price, \$3.00. Pp. 805. Philadelphia: J. B. Lippincott Company, 1949.

New and Nonofficial Remedies is published annually by the Council on Pharmacy and Chemistry of the American Medical Association and contains a description of preparations and articles which have been examined and accepted by the Council for that publication. The book provides statements on actions, uses, dosage, tests and standards of the preparations and articles. It also includes certain official preparations and other articles, including drug substances for manufacturing use for which there are not official standards, which the Council is of the opinion should be included for the information of the medical profession. The present volume contains descriptions of the articles which stand accepted by the Council on Jan. 1, 1949.

HOW TO BECOME A DOCTOR. By George R. Moon, A.B., M.A. Price, \$2.00. Pp. 131. Philadelphia: The Blakiston Company, 1949.

To read this book is like sitting down with someone and discussing a future career. It is written to aid would-be doctors in planning their training, in evaluating or improving their chances for entry into a professional school and in clarifying the probabilities for success after graduation. Mr. Moon, Examiner and Recorder of the University of Illinois Colleges of Medicine, Dentistry and Pharmacy, is unusually well qualified to provide sound and accurate information on this subject, for he has served as a registrar and a member of admission committees for twenty years, interviewing some 20,000 prospective medical students.

Ten chapters are devoted to a summary of the admission requirements of the leading medical schools, a description of the methods followed by admitting committees in selecting new medical students, a discussion of the medical curriculum and the chances for a student to succeed or fail, and an analysis of the number of related problems including finances, housing, outside employment, internships and residencies. Brief chapters on the two closely allied professions of dentistry and pharmacy are included. A final chapter deals with other professional fields closely allied to allopathic medicine, including veterinary medicine, optometry, chiropody, occupational therapy, hospital administration, medical illustration and science.

MEDICINE THROUGHOUT ANTIQUITY. By Benjamin Lee Gordon, M.D. Price, \$6.00. Pp. 818. Illustrations, 157. Philadelphia: F. A. Davis Company, 1949.

Here is a fascinating account of medicine as it was conceived, developed and practiced by the various peoples of antiquity. This distinguished and comprehensive work is, in many ways, distinctive in the literature on medical history. It traces the history of medicine step by step from the dim days of prehistoric antiquity to the end of the Greco-Roman period which terminated with the fall of Rome in 476 A. D.—the date when most histories of medicine begin.

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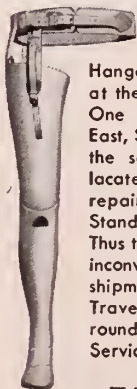
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Thoroughly documented, the book supplements rather than parallels other texts and contains much that is little known. Dr. Gordon carefully permits the ancient records and the ancient doctors to speak for themselves. In compiling a veritable history of human development and culture, he has confined his investigations to widely recognized and not ordinarily accessible sources and to discoveries in the fields of archeology, anthropology and paleopathology which in recent years have thrown a flood of light on prehistoric medicine. His work is critical, and in some ways organized and synthesized along completely new lines. From the period when the art of medicine was believed to be a direct revelation of the gods, he progresses through to a profound coverage of the Roman and Talmudic periods of medicine. Time and again, he throws light on modern medicine, and at every turn the reader feels that the book hails from the pen of a practicing physician.

INTERNATIONAL DIGEST OF HEALTH LEGISLATION. World Health Organization. Price, \$1.25. Pp. 144. Geneva: Palais des Nations, 1948.

This is the first number of the International Digest of Health Legislation. This publication is the successor to the first section of the Bulletin Mensuel de l'Office International d'Hygiène Publique, the section devoted to public health legislation. It is to consist of reprints and translations of, or extracts from, the texts of the most important laws and regulations dealing with public health and related subjects adopted in different countries. It is intended for all who are interested in the administrative and legislative aspects of public health, and its ultimate scope and character will be determined by such evidence as the World Health Organization can obtain of its utility. Criticisms and suggestions, especially from national and regional health administrations, are invited to help make the Digest an internationally useful source of reference for all aspects of health legislation.

There are separate editions in the English and French languages, and each edition is issued in two forms—as a bound periodical, and as a collection of separate fascicles in a loose cover to permit filing by subject or country. An index to each volume will be published. Orders may be addressed to World Health Organization, Sales Section, Palais des Nations, Geneva, Switzerland, or to Columbia University Press International Documents Service, 2960 Broadway, New York 27, N. Y.

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From where I sit *by Joe Marsh*

For the Ladies: A Diet That Really Works

We went out visiting the other night and the ladies were talking away about weight-reducing diets. One of them had a special "15-day Hollywood diet" guaranteed to slim her down fifteen pounds' worth. Another was living on bananas and skim milk!

I might have known the missus would get the bug, too, and sure enough the other day she asks me, "Joe, what kind of a diet do you think I ought to go on?"

"Mother," I says, "the only diet I would ever recommend to anyone is simply moderation. I wouldn't trust any of those get-thin-quick diets. Simply cut down on desserts, bread, butter, sweets and fats—but when you do, even do your cutting down moderately."

From where I sit, moderation is the watchword. Moderation with food, with smoking or with the enjoyment of a friendly glass of temperate beer or ale. Actually, moderation *adds* to the enjoyment of just about anything.

Joe Marsh



Long lines of black ants attracted to madhumeha, "honey urine," led the ancient Hindu wise men to observe and recognize diabetic urine, which they described as "astringent, sweet, white and sharp." Avid insects became an acknowledged means of diagnosis. Almost equally primitive methods of urine-sugar detection remained in effect for a score or more of centuries, until modern copper reduction tests were perfected, refined and simplified.



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of your patients... The farm housewife whose work is truly never done may find that the distressing symptoms of the climacteric make the smallest chore an arduous project. She depends on your help to resume normal efficiency in the performance of her daily tasks as well as to maintain a positive outlook during this trying period.

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4. This "Plus" (the sense of well-being enjoyed by the patient) is conducive to a highly satisfactory patient-doctor relationship.
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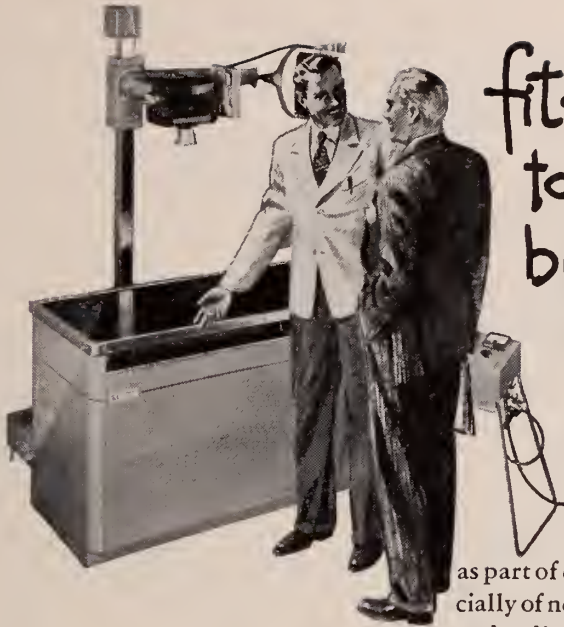
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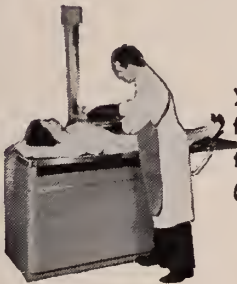
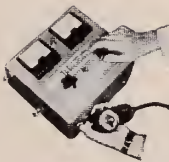


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<i>trachoma</i>	

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Feinberg, S. M.: Postgrad. Med. 3: 92 (1948).

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Levin, L.; Kelly, J. F., and Schwartz, E.: New York State J. Med. 48: 1474 (1948).

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Brown, G. T.: M. Ann. District of Columbia 16:675 (1947).

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Rosen, F. L.: J. M. Soc. New Jersey 45: 390 (1948).

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Quincy, Oct. 24, 1949
Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Palatka, Oct. 26, 1949
Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Sebring, Oct. 27, 1949
Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	Ft. Lauderdale, Oct. 28, 1949
Specialty Societies			
Podiatric Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Podiatry, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Podiatry, Am. Coll. Chest Phys.	Earlworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Podiatry and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Podiatric Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Podiatric & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Podiatry & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Podiatric & Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Podiatric & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Podiatric Society		Plumer J. Manson, Miami	" "
Podiatric Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Podiatric Association, State	Edgar W. Stephens, Jr., W. P. Beach	Hugh A. Carithers, Jacksonville	" "
Podiatric Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Podiatric Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Podiatric Society	A. Fred Turner, Jr., Orlando	Linus W. Hewit, Tampa	" "
Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '49
Medical Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, Nov. 27-29, '49
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Medical Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, April, 1950
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
Woman Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
Woman Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loran, Birmingham	Cincinnati, Nov. 14-17, '49
Woman Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	April 5-7, 1950
Eastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., 1950
Eastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5, '50
Eastern Surgical Congress	R. J. Wilkinson	B. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
East Clinical Society	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	Pensacola, Oct. 6-7, '49

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A

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Martle F. Parker, M.D. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		15	100%	A-1-50 William P. Hixon, M.D. Pensacola
Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	64	60	
Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Wewahitchika	3rd Tuesday Odd Months	7	6	
Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	17	
Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	44	42	
Suwannee	Joshua M. Price, M.D. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		6	100%	
Madison	A. Franklin Harrison, M.D. Madison	Merwin E. Buchwald, M.D. Box 214 Madison		4	100%	
Taylor *Davis-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	197

B

Alachua *Bradford, Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	39	100%	B-3-50 Charles C. Grace, M.D. St. Augustine
Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	252	235	
Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertraud F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	31	29	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
Brevard	Charles E. Russell, M.D. Box 9 Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	100%	
Lake *Suwanter	LeRoy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	20	100%	
Orange *Oxocola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	133	129	
Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	55	54	590

C

Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Hersehel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	154	153	C-5-51 M. Crego Smith, M.D. Clearwater
Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	21	19	
Pasco-Hernando- Citrus	Donald G. Bradshaw, M.D. Zephyrhills	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	11	100%	
Pinellas	Francis H. Langley 190 18th Ave., N. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	162	161	
Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Tahmadge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	27	25	
DeSoto-Hardee- Highlands- Charlotte-Glades	John A. Simmons, M.D. Box 430 Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	29	100%	C-6-50 H. Quillian Jones, M.D. Ft. Myers
Lee *Collier, Hendry	Curtis R. House, M.D. 2 Darling Bldg. Ft. Myers	Joseph L. Selden, Jr., M.D. 416 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	23	22	
Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	80	77	507

D

Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
Palm Beach	William E. Bippus, M.D. Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	93	91	
St. Lucie- Okeechobee- Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	12	11	
Broward	Paul G. Shell, M.D. 420 Sweet Bldg. Ft. Lauderdale	Scottie J. Wilson, M.D. 309 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	67	65	D-8-51 S. Marion Salley, M.D. Miami
Dade	John D. Milton, M.D. 1105 Huntington Bldg. Miami	Benjamin G. Oren, M.D. 1431 N. Bayshore Dr. Miami	1st Tuesday 8:30 P.M.	508	473	
Monroe	Frank E. Bowser, M.D. 420 Simonton St. Key West	Wallace H. Mitchell, M.D. 217 Duval St. Key West	2nd Thursday 8:00 P.M.	13	100%	701



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HIGH
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1. Brewster, J. M., U. S. Naval Med. Bull. 49: 1-11, January-February 1949.

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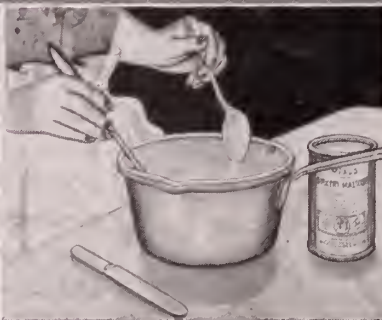
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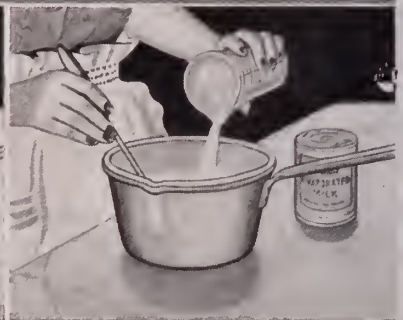
1 Boil water.



2 Stir in Dextri-Maltose while water is hot.



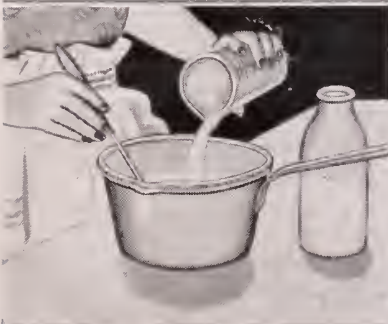
3 Add evaporated milk and stir.



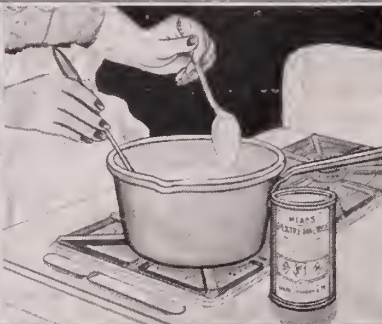
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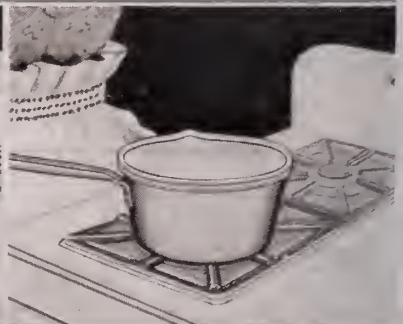
1 Mix whole milk and water.



2 Heat until almost boiling and stir in Dextri-Maltose.



3 Boil gently for three minutes.



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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

OCTOBER, 1949

No. 4

IN THIS ISSUE

Low-Fused Back

Royston Miller, Newton C. McCollough
and Eugene L. Jewett



Puerperal Infection

Homer L. Pearson, Jr.



Infertility

Oren A. Ellingson



Truman Loses, Medicine Wins Battle on Reorganization Plan

An Editorial



Medical District Meetings October 24-28, 1949

Page 235



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CONTENTS

SCIENTIFIC ARTICLES

Early Ambulation of the Low-Fused Back, Royston Miller, M.D., Newton C. McCollough, M.D., and Eugene L. Jewett, M.D.	211
Modern Concepts in the Prevention and Treatment of Puerperal Infection, Homer L. Pearson, Jr., M.D.	215
Diagnosis and Treatment of Infertility, Oren A. Ellingson, M.D.	219
Industrial Dermatitis in Florida, John M. McDonald, M.D.	223
Diagnosis and Early Treatment of Poliomyelitis, William F. Friedewald, M.D.	225

ABSTRACTS OF MEDICAL ARTICLES

Venereal Granulomas: a Comparative Study of These Diseases in Florida, Wesley W. Wilson, M.D.	227
Modified Irrigating Solution for Transurethral Prostatic Resections: a Preliminary Report, T. Allen Dees, W. Dean Steward, Edward F. Meares and Louis M. Orr	227
Congenital Extrinsic Duodenal Obstruction in the New Born, Report of Two Cases, Joseph S. Stewart, M.D.	227
Pentobarbital Sodium—Curare Induction for Endotracheal Intubation, H. Carron, M.D., V. K. Stoelting, M.D., and S. C. Cullen, M.D.	227
Basal Metabolic Rate in Diagnosis, Iva C. Youmans, M.D.	228

EDITORIALS

Truman Loses, Medicine Wins Battle on Reorganization Plan	230
"Utopia on the Rocks"	231
Penicillin Rivals Forge Ahead	232
Make It Real	233
An Age of Age	234

COMMENTARIES

Let's Be Ready for the Next Round	234
Medical District Meetings, October 24-28, 1949	235
A. M. A. School Health Conference, October 13-15	235

GENERAL FEATURES

Officers and Committees	228, 229
Your Blue Shield	236
National Education Campaign	236
State News Items	237
Births and Deaths	237
Medical Officers Returned	238
New Members	238
Component Society Notes	238
Obituaries	238
Woman's Auxiliary	243
Schedule of Meetings	253
List of County Medical Societies, Presidents and Secretaries	254

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★ *Epileptic Men of Genius* ★

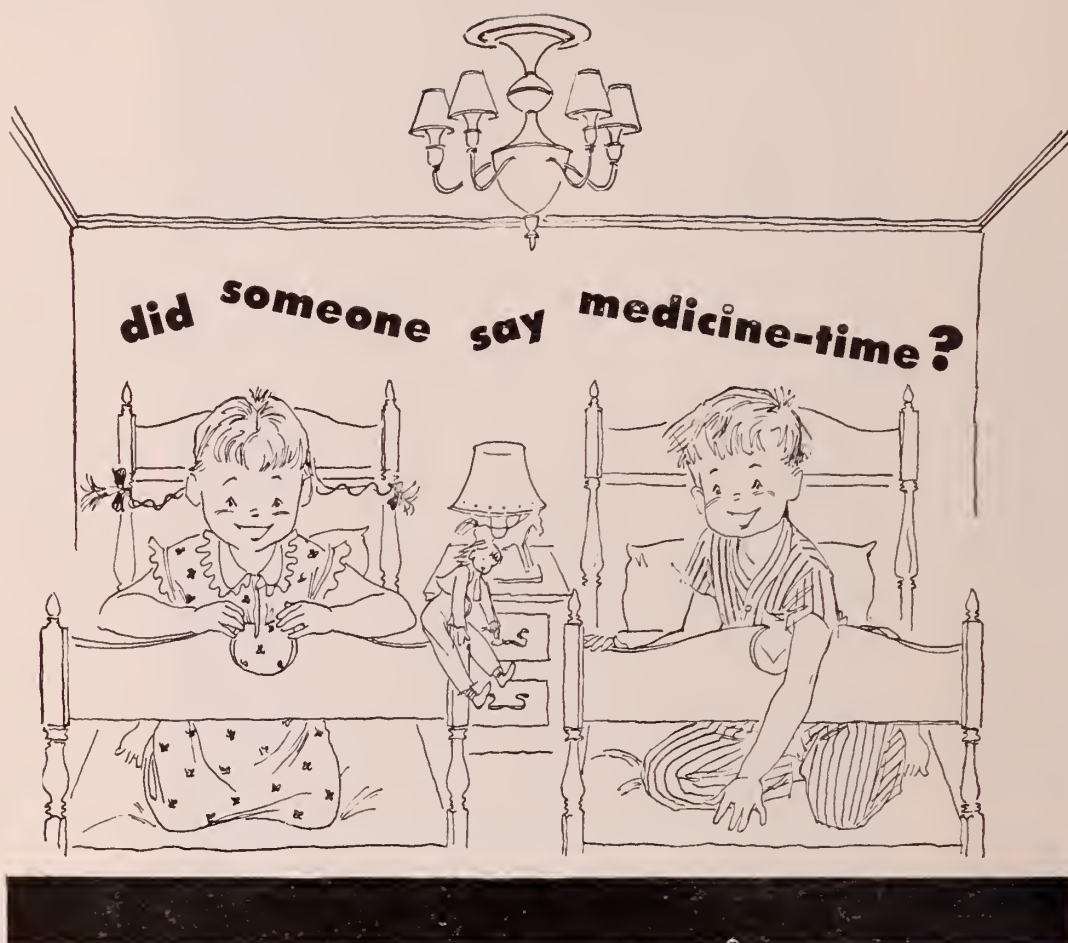
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References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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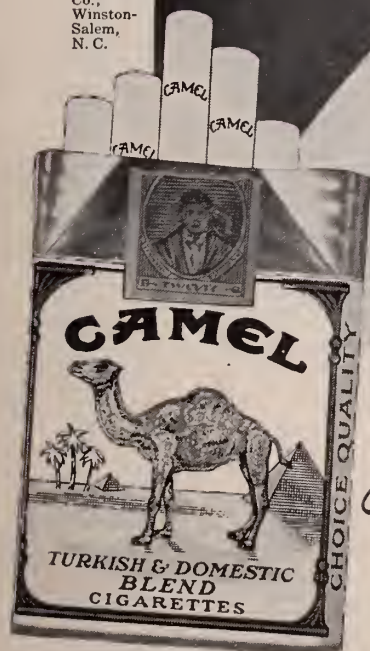
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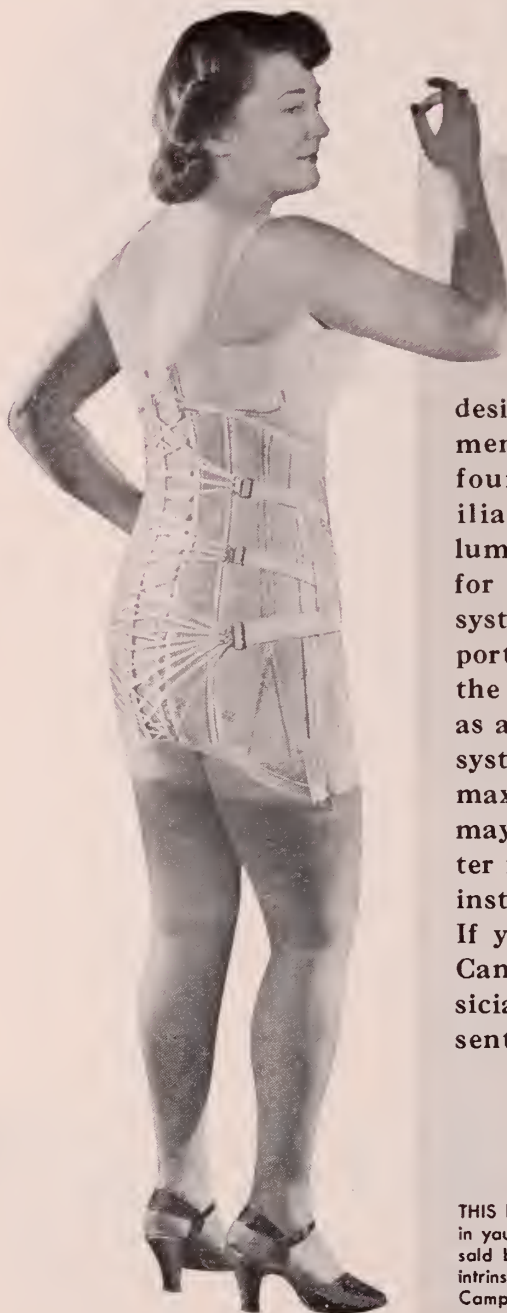
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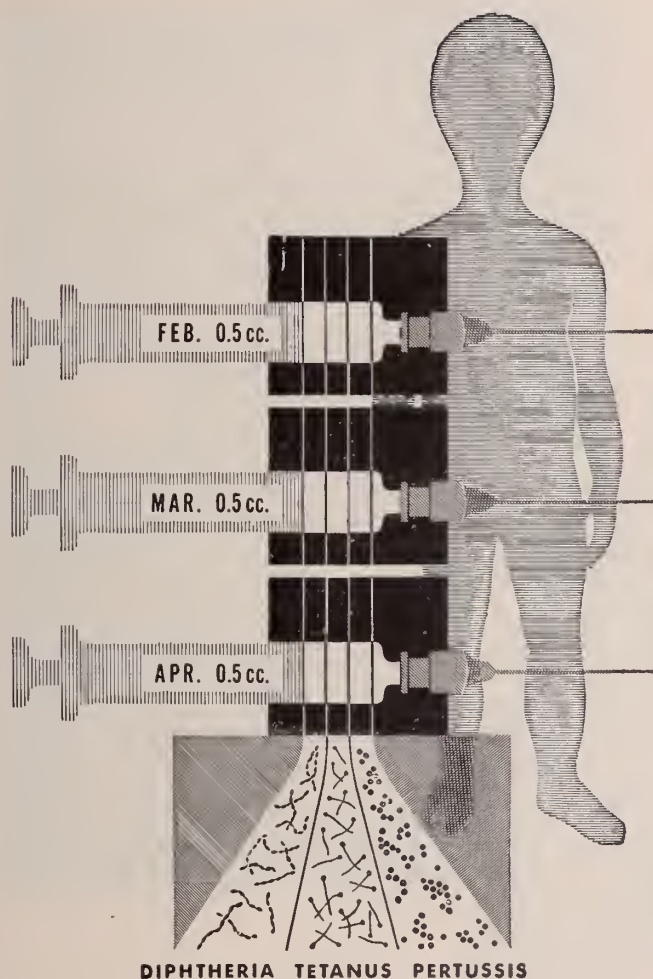
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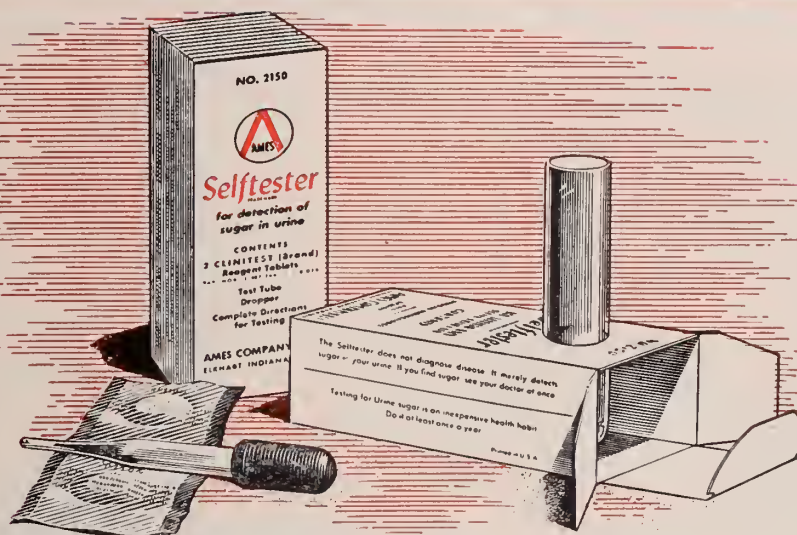
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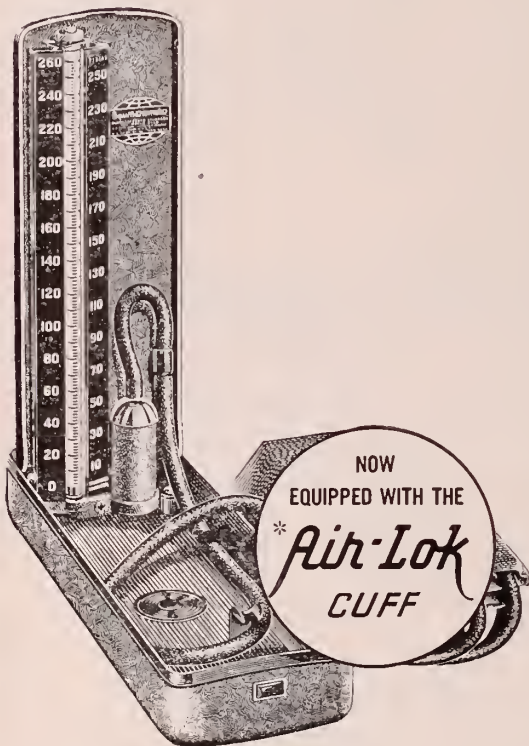
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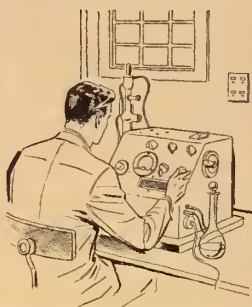
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Early Ambulation of the Low-Fused Back

ROYSTON MILLER, M.D.

NEWTON C. MCCOLLOUGH, M.D.

AND

EUGENE L. JEWETT, M.D.

ORLANDO

Spinal fusion has become an increasingly important surgical procedure in the armamentarium of the orthopedic surgeon. It is used for rehabilitation in various types of low back disabilities that have failed to respond to the usual conservative course of treatment and have rendered the patient incapable of performing his usual work.

Until recently long periods of postoperative rigid immobilization and hospital care have made the procedure a financial catastrophe to one of ordinary circumstances and have caused various insurance problems due to the financial obligation that is anticipated. Patients were not prone to have themselves incarcerated in a cast, in bed, for three or four months at a time. This treatment also has increased hazards to the patient in the production of phlebothrombosis and other complications. These, among other factors, such as the failure to get a fusion in approximately 20 per cent of all cases, have led numerous orthopedists to try to work out means by which internal fixation can be used in low back fusions in order to make the patient ambulatory earlier and independent of hospital care.

Early ambulation following low spinal fusion can be accomplished only by some method of rigid internal fixation. This must be augmented by the use of a well fitted high lumbosacral brace or body cast.

One of the means used to attain this end has been the employment of metallic devices, such as plates, screws, bolts and wires, to help maintain a rigid fixation of the fusion area. This method has many points in its favor, but there are distinct drawbacks medicolegally and clinically to the inclusion of any metallic substance in or about the

spine. Another consideration with regard to these monosteogenic substances is that wires often break, screws become loose, nuts become detached from bolts, and plates still bend and break. Also, foreign body reaction with chronic drainage can occur.

Because of the fact that in the normal lumbosacral spine there is a lordosis with tendency toward hyperextension, we concluded that this postural force should be utilized as part of the surgical procedure in order to make the relatively unstable segments stable. Autogenous grafts locked by this force have produced the necessary long-continued rigidity. Mechanically, H type grafts between the spinous processes and block grafts across the facets have proved most reliable.

After carefully evaluating the results of these methods we now use as a primary operation or combined with the removal of an intervertebral disk the following type of low back fusion: Through a lower midline incision the spinous processes, laminae and facets are subperiosteally exposed in the usual manner. Block grafts are inlaid across the facets as shown in figure 1, and the laminae are feathered according to the methods of Hibbs. Then, iliac bone, usually of two thicknesses, is used as an interlocking graft of the H or clothespin type, which is put in tightly between the spinous processes with the patient in acute flexion. This flexion is also increased by use of a spreader on the laminae which forces the spinous processes and laminae farther apart, and the graft is then inserted as shown in figure 2. Following this procedure the spine is extended into the normal prone position, and the vertebrae are then tested for their stability. This is dramatic and is noted without any difficulty. If the interlocking grafts and block grafts are not stable, they are

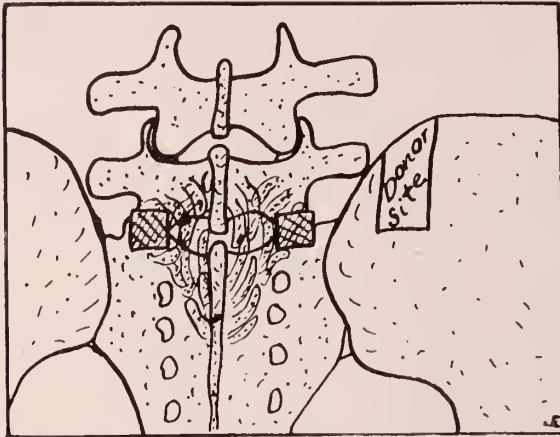


Fig. 1.—Diagram of block grafts from single thickness ilium set into beds made by removing all of the articular cartilages and contiguous bone.

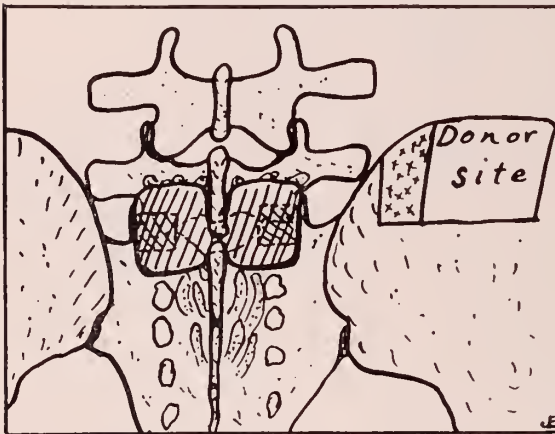


Fig. 2.—Diagram of interlocking H or clothespin grafts taken from full thickness ilium. This graft is locked into the spinous processes and covers closely the facet grafts.

removed and readjusted so that they become stable. Numerous cancellous grafts are then placed around and between the block grafts in order that these may become more productive of bone. Likewise, it will be noted that the interlocking grafts are large enough to tend to fix the facet grafts which have been placed originally. Thereafter, closure is carried out in the usual manner, and the patient is returned to his bed on a fracture board with a firm mattress. Nursing care is then simplified by the fact that as soon as the patient recovers from the effects of the anesthetic he may be rolled from side to side and lie on his face if he so desires.

Graduated ambulation is permitted in about three weeks with the brace shown in figure 3 applied. Postoperative roentgenograms are taken at

month to six week intervals to determine the position of the grafts and to note the fusion that is taking place. At the end of three months, flexion, extension or lateral bending roentgenograms are taken, and the amount of fusion is observed. The brace is allowed to remain on until osteogenesis has matured.

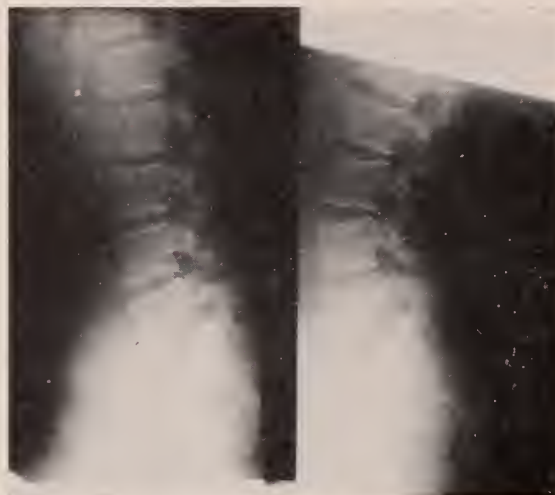
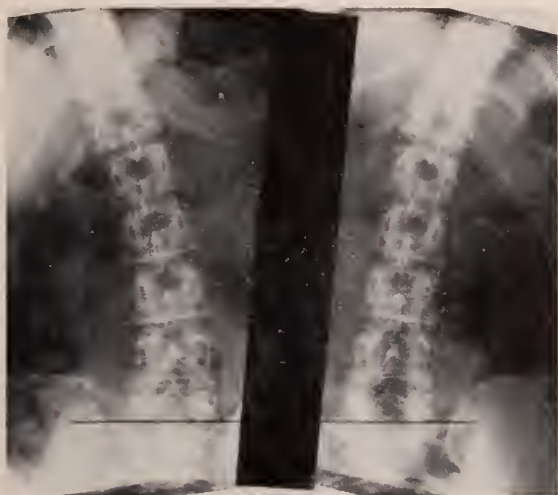
Iliac bone, we believe, is preferable to tibial for a number of reasons. The invasion of the tibia offers a portal of entry for bacteria and definitely predisposes the shaft to fracture for a considerable period of time. The osteogenetic quality of the ilium, namely, cancellous bone, has come to be recognized as superior to the tibial cortex and is probably more rapidly encompassed and invaded by the process of creeping substitution. This leads to an accelerated consolidation of the fusion. In this position, in which the force of compression is the principal stress upon the graft, the strength of iliac bone (table 1) has proved sufficient to maintain rigidity.

The placement of the grafts so that they fix the lumbosacral joint in relative flexion with subsequent fusion in this position provides a decrease in lumbar lordosis which offers better postural dynamics for the lumbar segments proximal to the fused area.

It has been observed by many that the greater the number of segments operated upon for fusion of the spine the greater the number of failures. The percentage of failure has been estimated to increase about 15 per cent for each segment added. By proper evaluation and limitation of the at-



Fig. 3.—Brace, side view.



Figs. 4. and 5.—Bending roentgenograms to show rigidity of the fusion.

tempted fusion only to the involved area, a higher percentage of successes can be expected.

A summary of 27 consecutive cases treated in the last thirteen months by the method described is presented in table 1. By the term "excellent" we mean the patient is back at his regular work without his brace and is asymptomatic. The more recent patients designated as asymptomatic are wearing their braces during the daytime but not at night. Several of these are back at light or office work, some part time and a few full time.

Conclusion

A type of low spinal fusion has been described which provides sufficient osteogenetic internal fixation to permit early ambulation with a brace. A series of 27 consecutive cases is reported. This preliminary study indicates that the desired postoperative course has not been delayed and none of the usual complications of prolonged immobilization have presented themselves.

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Discussion

DR. FRANK L. FORT, Jacksonville: I should like to stress the fact that Dr. Jewett in his paper claimed nothing original, but he has given what I believe to be an up-to-date summary of the progress made in treating low back conditions. Low back pain is one of the commonest of human complaints. Diagnosis and treatment are unsatisfactory. Low back pain is one of the unsolved problems in orthopedic surgery. No one treatment is satisfactory.

The operative procedure outlined by Dr. Jewett is probably the best that has yet been devised for permanent relief of low back pain in many instances. There are some who would argue that the wedge graft is a better operation, but in some cases in any type of bone grafting operation the grafts do not fuse to the vertebra and, therefore, fail to relieve pain. I agree with Dr. Jewett that the iliac bone graft is better than the average tibial graft. The graft is easier to take; it is more vascular and has greater osteogenetic powers.

Dr. Jewett stated in his preamble that he reduced postoperative immobilization after his bone-grafting operation. I note that he does immobilize the spine after surgery, but probably for shorter periods of time than most of us have been doing. I think postoperative immobilization, after the spinal bone graft operation, is of prime importance. Inadequate immobilization is the most frequent cause of faulty fusion and, therefore, unsatisfactory operation. The statistics from various clinics show failures on an average in 10 per cent to 20 per cent of the cases in which an operation is performed. Twenty per cent failure is too much for any operation to be considered as a good operation. In my opinion this percentage of failure can be avoided by longer immobilization and better immobilization after surgery.

It is my practice to keep the patient flat in bed for two weeks after spinal fusion operations. When the incision has healed, a body cast with a short one leg spica is applied and worn for ten weeks. Three months after operation a metal back brace is applied and worn for

Table 1. Analysis of Twenty-Seven Cases of Low Back Fusion

Patient	Sex	Age	Ruptured Disk	Other Conditions	Type of Operation	In Bed	In Brace	Time Post-operatively	Results
W.W.	M	15	No	Spondylolisthesis L5	C. P. graft and Hibbs L4, 5, S1	5 wks.	4 mo.	1 yr. 1 mo.	Excellent
E.F.D.	F	44	No	Thin L5 disk, fracture of L5 body	C. P. graft and Hibbs L4, 5, S1	6 wks.	9 mo.	11 mo.	Excellent
M.S.	F	45	L4, 5, 6, left	Spondylolisthesis L5	C. P. graft and Hibbs L3, 4, 5, S1	8 wks.	7½ mo.	10 mo.	Excellent
R.C.	M	34	No	Thin L5 disk and arthritis	C. P. graft and Hibbs L4, 5, S1	4½ wks.	2 mo.	9½ mo.	Poor—removed brace too early
R.J.	M	17	No	Spondylolisthesis L5	C. P. graft and Hibbs L4, 5, S1	4 wks.	6 mo.	8 mo.	Excellent
J.D.	M	17	L5, right	Thin L5 disk	C. P. graft and Hibbs L5, S1	2 wks.	2½ mo.	6 mo.	Excellent—removed brace early
J.H.A.	F	37	L5, left	Thin L5 disk and arthritis	C. P. graft and Hibbs L5, S1	3 wks.	At present	5½ mo.	Too early to tell, but asymptomatic
J.Mc.	F	18	No	Spondylolisthesis L5, S1	C. P. graft and Hibbs L4, 5, S1	4 wks.	At present	5 mo.	Too early, phlebothrombosis, right
C.E.	M	42	L5, left	Thin L5 disk and arthritis	C. P. graft and Hibbs L5, S1	3 wks.	At present	5 mo.	Too early to tell, but asymptomatic
J.L.	M	47	L4, L5	Arthritis, low back	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	4½ mo.	Too early to tell, but asymptomatic
B.H.R.	F	62	No	Thin L5 disk and arthritis	C. P. graft and Hibbs L4, 5, S1	3½ wks.	At present	4 mo.	Too early to tell, but satisfactory
B.M.H.	F	33	No	Scoliosis and arthritis	C. P. graft and Hibbs L2, 3, 4, 5, S1	8 wks.	At present	4 mo.	Virus of chest, doing well
A.E.O.	F	39	L5, right	Arthritis and herniated disk	C. P. graft and Hibbs L4, 5, S1	5 wks.	At present	3½ mo.	Infected hematoma, doing well
R.W.	F	26	L5, right	Thin L5 disk	C. P. graft and Hibbs L5, S1	3 wks.	At present	3 mo.	Asymptomatic, doing well
W.H.A.	F	66	No	Thin L5 disk and arthritis	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	3 mo.	Asymptomatic, doing well
L.C.	M	34	L5, right	Thin L5 disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	3 mo.	Some numbness, doing well
W.T.M.	M	33	No	Fracture, right third lumbar facet	C. P. graft and Hibbs L3, 4	3 wks.	At present	3 mo.	Asymptomatic
H.A.	M	35	No	Spondylolisthesis	C. P. graft and Hibbs Block, L4, 5, S1	3 wks.	At present	2½ mo.	Asymptomatic
J.L.O.	M	29	L4, right	Reverse Spondylolisthesis	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	2½ mo.	Asymptomatic
J.T.P.	M	31	L5, left	Thin L5 disk	C. P. graft and Hibbs L5, S1	3 wks.	At present	2½ mo.	Asymptomatic
S.G.N.	M	42	L5, left	Reverse spondylolisthesis	C. P. graft and Hibbs L5, S1	3 wks.	At present	2½ mo.	Asymptomatic
L.D.	F	32	L4, 5, right	Thin L5 disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	2 mo.	Asymptomatic
D.Z.	F	38	No	Pseudarthrosis, spinal fusion	C. P. graft and Hibbs L3, 4	4 wks.	In bed	4 wks.	Asymptomatic
J.K.E.	F	50	L5, right	Thin L5 disk	C. P. graft and Hibbs L5, S1	3 wks.	At present	4 wks.	Asymptomatic
L.E.T.	F	40	L4, 5, right	Thin L5 disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	4 wks.	Asymptomatic
C.K.	M	36	L5, right	Thin L5 disk and arthritis	C. P. graft and Hibbs L5, S1	3 wks.	At present	4 wks.	Asymptomatic
H.B.C.	F	24	L4, 5, left	Thin L5 disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	4 wks.	Asymptomatic

another three months. Of course, the cast is uncomfortably hot and irritating, but it is more foolproof than the back brace. One cannot depend upon the cooperation of some patients. The noncooperative patient should be locked up in the cast so that he cannot do himself any harm. The patient can be dismissed from the hospital on an average of three weeks after the operation. He is disabled completely for twelve weeks, but can do light work after twelve weeks. The great majority are able to do regular work six or seven months after the fusion operation. I have had practically no failure of fusion in the past five years, or since following the procedure outlined.

Dr. Jewett is to be commended on presenting his paper on this subject at this time. He has given a conservative report on what can be expected and what cannot be done in the average case requiring spinal fusion.

He has given in my opinion as good a method, if not the best method, as yet devised in treating the chronic low back pain which does not respond to conservative treatment.

DR. MILLER, concluding: I wish to thank Dr. Fort for his very kind discussion of our paper. Also, I should like to say that we think the wedge type graft is essential for a good osteogenesis. In practice, pressure rather than distraction hastens the maturity of a graft. We believe that in this method the use of the brace and allowing the patient to be ambulatory make him more or less dependent upon caring for himself for a long period. Using a spica for three months is relatively an uncomfortable feeling. It may, however, help out in decreasing the number of failures. We cannot state the definite degree of fusion which occurs over this short period of time.

Modern Concepts in the Prevention and Treatment of Puerperal Infection

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Since the development of specific chemotherapeutic agents and antibiotics, in the last twelve to fifteen years, the treatment of puerperal infection has not undergone such material changes, but we physicians now have ammunition which we did not have before with which to fight the disease. Happily, we have greatly lowered the maternal morbidity and mortality rates. Neither has there been any great change in the methods of prevention of this disease. We have observed that through education of the public and a more enthusiastic application by the profession of the principles of prophylaxis, we have brought about a materially lowered incidence of the disease.

It is well to remember in this, as well as in all preventable diseases, that there is much greater satisfaction in preventing infection than in treating it. However much we might like to deny the responsibility and try to prove that it was not our fault, the onus for the infection must be assumed by the physician in charge unless he can definitely prove the source of infection was in no way connected with the hospital or attendants. In the face of infection there is therefore a feeling of guilt that we have been careless or negligent in some respect.

Preventive Measures

Our prophylaxis against the infection should begin with the patient's first antepartum visit. Careful evaluation of her general state of health should be made by ardent search for possible foci of infection, and when found, they should be adequately treated. She should receive detailed instructions regarding local cleanliness; tub baths and sexual relations are prohibited after the seventh month; secondary anemia must be overcome by the use of iron, liver, vitamins and, if necessary, blood transfusions. Her diet should be such as to insure good nutrition but to avoid overweight. Such measures should insure a high standard of general health and thus increase her resistance to infection.

During labor and delivery we must use the greatest care in the prevention of infection. The patient should receive a shower or at least a sponge bath before admission to the labor room. Her genitalia should then be carefully prepared, and we think it wise to instil an ounce or two of a nonirritating antiseptic solution such as 1:1000 zephiran chloride in the vagina. This measure should be repeated several times during a long labor. Rectal examinations should be made to determine the progress of labor, but should not be made indiscriminately. Vaginal examinations

are to be made when necessary, but only under the strictest aseptic technic.

The delivery must be conducted under rigid surgical aseptic technic. Frequent liberal use of zephiran chloride to bathe the vagina and external genitalia during the final moments of delivery is not amiss.

Meddlesome midwifery, such as manual dilatation of the cervix and premature application of the forceps, is condemned strongly as it greatly increases the danger of infection. We believe, however, that the outlet forceps with a well performed episiotomy is of advantage rather than permitting the head to pound for a long time upon a rigid perineum.

The third stage of labor should be permitted to proceed normally. The uterus should not be entered unless it is absolutely necessary; neither should fragments of placenta be left in the uterine cavity. Following delivery, again, liberal use of zephiran chloride can be of advantage. Careful repair of the cervix, vagina, pelvic floor and perineum should be made, using needles of small caliber and very fine catgut.

Postpartum prophylaxis depends largely upon good nursing care. The perineum is treated as a clean surgical wound, with avoidance as far as possible of contamination. The patient receives one of the ergot derivatives to insure firm contraction of the uterus. If the blood loss has been great, then blood is replaced by transfusion. Overdistention of the bladder must be prevented.

Treatment

So much for the prevention of puerperal infection. We will now discuss the treatment without going into the signs and symptoms of the disease. Of course, we know that the infection may be endogenous or exogenous in origin, but in the vast majority of instances it is exogenous, and to discuss the active treatment of the infection we must have some knowledge of the pathology. We can say it is a simple wound infection generally. The birth canal is always a wound surface whose extent is dependent upon the following factors: the placental site and endometrium; lacerations of the uterine body and cervix; contusions or lacerations of the vaginal vault, vulva or perineum. These infections ordinarily remain local, but extension may occur through the lymphatics, through the venous system and by continuity of surfaces. We may, therefore, encounter a vulvitis

and vaginitis; an endometritis or sapremia; a metritis; a pelvic cellulitis or parametritis; a pelvic peritonitis or a perimetritis. Decidedly, the most serious of all the infections is bacteremia or septicemia. Further complications, of course, may occur, such as a pyemia or metastatic bacteremia or a thrombophlebitis. We believe that we can have one or all of these conditions to combat in one patient. We can be thankful, however, that such is not usually the case. Many times the more serious conditions are simply extensions of the less serious ones, and if in the simple cases treatment is administered early and adequately the most serious ones can be avoided.

We might state at the outset that nearly any organism might be capable of causing puerperal infection. At least twenty different predominating organisms have been cultured in infected cases; seldom was only one organism found, and as many as six or eight may be found in a single case. About 85 per cent of all cases are, however, due to streptococci or staphylococci, pneumococci, colon bacilli and gonococci, following in that order. Colebrook and Hare obtained positive blood cultures of *Streptococcus pyogenes* in 62 out of 100 cases of puerperal infection and in the same 100 demonstrated *Streptococcus anaerobius* thirty times. Conti and his co-workers studied cultures in 275 cases of puerperal infection; 275 aerobic cultures and 166 anaerobic cultures were planted, from which 37 different organisms were grown. Of these, 14.5 per cent were streptococci, but only 3.3 per cent were hemolytic streptococci. We have been unable to find any literature on the incidence of anaerobic streptococci, but it is a fairly well established fact that anaerobic streptococci predominate in infection associated with abortion.

Before the advent of simple blood transfusions, chemotherapy and the use of antibiotics, we were practically helpless in the face of puerperal infections. About all that we could do was to isolate the patient, give her supportive treatment and hope for the best. Since we have these new therapeutic agents readily at hand, it has become a fairly simple matter to treat the infected patient, with early recovery usually resulting. In the large clinics and teaching institutions, great emphasis is placed on the isolation of the offending organisms by lochial and blood cultures. We appreciate the fact that the ideal method of procedure is the early isolation of the offending organism and the application of the specific therapeutic

agent for such. We also think that we certainly should not wait until the offending organism has been isolated before treatment is instituted because much valuable time will be lost. Since we know that in the vast majority of cases the offending organisms are *Str. pyogenes*, *Streptococcus hemolyticus* and *Str. anaerobius* and that the specific therapeutic agent against these organisms is penicillin, we therefore can and do begin treatment at the same time that we take cultures.

Our usual routine is as follows: When the patient shows the usual signs of infection, we immediately isolate her. She is placed in a semisitting position to preserve good drainage. Liquids are increased and, if necessary, are administered intravenously, 3,000 to 4,000 cc. a day. Elimination is satisfactorily maintained by mild laxatives or enema. Lochial and blood cultures are taken. If the hemoglobin estimation is 70 per cent or below, or the red blood cell count is below 3,500,000, she is given transfusions, usually small ones frequently. We administer 30,000 units of penicillin every three hours, also sufficient sedation. These measures are usually adequate for the simple infections, and within forty-eight hours the temperature is usually normal again. If, however, the patient continues to have chills and elevation of temperature and there develops tenderness and rigidity of the lower part of the abdomen and of the pelvis, we increase the penicillin to 50,000 units every three hours and in addition give sulfadiazine, 1 Gm. every four hours. She is alkalinized with sodium bicarbonate. If distention continues or increases, we make use of the Wangensteen apparatus and give morphine 1/6 to 1/4 grain as required. She is given rather large quantities of vitamins B and C. Careful observation for evidence of abscess formation is made and, of course, if and when it occurs and only after complete localization with evidence of it being completely walled off, are an incision and drainage indicated.

When the characteristic symptoms of bacteremia or septicemia occur, such as violent chills lasting from five to thirty minutes and high elevation of temperature which is spiked, and even without the positive blood culture, we continue the aforementioned treatment with the use of 50,000 units of penicillin every three hours intravenously. The use of penicillin is contraindicated because it is ineffective if infection is due to *Bacillus coli*, *Bacillus proteus* or Friedlander's

bacillus. In all cases in which infection is due to these gram-negative bacteria, sulfonamides are used. Sulfadiazine is the most effective and generally the one better tolerated by the patient.

We have had two occasions to use the antibiotic streptomycin. One was in a case in which we had done a cesarean section and found evidence of active infection of *B. coli*. While it is impossible to draw definite conclusions from 1 case, we think it remarkable that this patient recovered in the face of active infection with *B. coli* and in all probability with various other organisms which are usually causative agents in puerperal infections. The other case was one of fully developed generalized infection fourteen days postpartum with peritonitis, ileus and pneumonia. Even though this patient had a stormy convalescence, she recovered on large doses of streptomycin, penicillin and sulfadiazine. Streptomycin promises to be specific in the treatment of infections caused by certain gram-negative bacteria, as *B. coli*, *Eberthella typhosa* and Friedlander's bacillus.

Infection may develop into the more chronic form of sepsis, namely pyemia. It is usually secondary to local uterine infection in which venous thrombosis has occurred. The treatment for this condition combines the specific measures employed in bacteremia and the incision and drainage of local abscesses which form.

Thrombophlebitis or an infection of the veins with thrombus formation may occur after severe trauma during delivery or in association with local infection. It usually begins in the uterus as a local thrombophlebitis and extends by way of the pelvic veins through the common iliac veins either upward into the vena cava or downward through the external iliac into the femoral veins. It may be suppurative or nonsuppurative. In the suppurative form embolic phenomena are characteristic. The best example of the nonsuppurative variety is femoral thrombophlebitis, or phlegmasia alba dolens or milk-leg. This condition some few years ago was common, but it is now becoming one of the rare diseases following pregnancy. The treatment of femoral thrombophlebitis is the usual elevation of the leg with complete rest, supportive bandage and application of heat. This treatment is now supplanted by paravertebral block. There is usually prompt relief of pain and swelling. Dicumarol and heparin have also been used with considerable success, but their use is not without danger. Continuous caudal or continuous spinal

anesthesia has also been used successfully by some. The vasodilatation is greater and is maintained for the duration of the anesthesia, which may be from four to twelve hours.

Under this routine we have markedly reduced morbidity and mortality from infection to zero.

Summary

Present day concepts of prophylaxis during the antepartum and postpartum period and of measures to prevent infection during the period of labor and delivery are reviewed. Treatment of puerperal infection is discussed in some detail. The role of blood transfusions, chemotherapy and antibiotics, with consequent reduction in morbidity and mortality, is described. The importance of determining the causative organisms is noted, but to avoid loss of valuable time required to ascertain reports of cultures, prompt treatment is advised in accordance with the routine outlined.

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Discussion

DR. CLELAND D. COCHRANE, Daytona Beach: It was with a great deal of pleasure that I accepted the invitation to discuss such an enlightening review of the modern concepts in the prevention and treatment of puerperal infections as that just read by Dr. Pearson. I am honored.

Anyone who has practiced twenty-five years or more in medicine and obstetrics has seen the gradual diminution of mortality and morbidity. Due to the teaching of the technic by De Lee, Williams, Stander, Beck, Titus, Polak, Kerr, Falls and others, with the arrival of specific agents

and antihistotics, there has been a decided diminution of mortality and morbidity. Recent statistics as given by the Public Health Service for 1947 show that the mortality and morbidity have declined steadily since 1933. In that year the mortality was 6.2 per thousand live births; in 1946 it was 1.6 per thousand, and in 1947 1.3 per thousand. In 1947 for white women the rate was 1.1 per thousand and for nonwhite 3.3 per thousand live births, while in 1933 the rate was 5.6 for white women and 9.7 for nonwhite per thousand live births. This reduction has, no doubt, been due to the factors Dr. Pearson named; even though during the war years there was the E.M.I.C. program and all that which the present day politicians would say was due to the free care as given by the doctors who subscribed to the E.M.I.C. program.

Dr. Pearson's enumeration of the steps taken in prophylaxis against infection I surely agree with, and I cannot too strongly emphasize. To re-emphasize it, I have typed sheets of diets and directions which are given to each patient on her first visit. At subsequent visits there are details brought up from time to time so that the patient can and will know what is expected of her. The technic of delivery and postpartum care is essentially the same as in all localities with variance as to the individual patient concerned.

Here I might add, even though it might seem mercenary, in the interest of good antepartum care I have an understanding with the patient and her husband as to the fee, so that if I want that patient to come to my office every day, she will not feel that she cannot come because of the expense involved. There is no office fee involved, and this fact definitely has a direct bearing on the attitude of the patient and her antepartum visits.

Much has been written concerning the bacteriology of the vaginal tract. To me, all these organisms are present normally as in other orifices of the body, but it takes lowered resistance and insults to the tissues to activate them. When these two or more conditions are present, we have the conditions named by Dr. Pearson, and the treatment in general should be as advised.

With our blood banks and the ability to obtain blood, I believe that with a hemoglobin estimation of less than 70 per cent or 11 Gm., either before or after delivery, transfusions are indicated, definitely. Resistance of the patient is vital, and the ratio of mortality and morbidity is in direct proportion to this resistance.

I too think that it is of definite value to ascertain the organisms; but it takes time to isolate the causative organism, and in these infections no time should be lost in treatment. The essayist has definitely stated the manner of extension of a simple infection, and if we wait to know the organism, the extension will become more serious—in other words, no watchful expectancy here.

The treatment of these patients in our locality is essentially the same. Strange though it may seem, we do not see too many cases of morbidity after excluding the temperatures from mastitis and pyelitis. This is no doubt due to the speed with which chemotherapy and antibiotics are prescribed, and to the short stay in the hospital so that if there is an infection there is no record of it in the hospital. Here I might mention a case in which phlebotrombosis developed three days postpartum. The highest temperature was 99.8. Normal spontaneous delivery was followed by surgical intervention immediately, and uneventful recovery; by the way, this patient is again pregnant. Last year we had 600 cases of delivery in our hospital, with 1 death in a case of acute fulminating toxemia.

In conclusion I wish to state that if the lines of treatment as laid down in this paper were carried out, there would be further diminution in the mortality and morbidity rates. I think that Dr. Pearson has definitely added to this diminution by his clear, explicit and brief treatment of this subject of the care and technic in the prevention and treatment of puerperal infections.

Diagnosis and Treatment of Infertility

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Approximately 15 per cent of married women 49 years of age have never borne children.¹ Adequate investigation and treatment of the childless couple can reduce this figure considerably. Such investigation does not necessarily require the services of specialists, but can be performed by any physician who manifests an earnest desire to help these unfortunate and unhappy people.

It is a common occurrence to see sterility patients who have passed through the hands of many physicians, but have never been thoroughly examined. They may have had a pelvic examination, been told they were normal, and advised to go home and keep trying. Perhaps the basal metabolic rate was determined. The husband's sperm might have been "looked at" and pronounced fit, but only rarely will one see a patient who has been adequately studied. An even more objectionable practice, however, is the habit of prescribing therapy for these patients without first determining the cause of the infertility. I recently saw a patient who had spent \$75 over a six month period for various hormone preparations, only to find that her husband, who had berated her for her inability to conceive, was hopelessly sterile. It is, therefore, my desire to present, not a statistical analysis of the results in my practice, but rather a resume of the latest methods of diagnosis and treatment of the infertile partnership.

Diagnosis

A complete medical, surgical, and endocrinologic history must be taken. One might ask, when is a couple considered infertile? I believe that any couple who has been unsuccessful in obtaining a pregnancy after a thorough trial of one year is relatively infertile.

The younger the couple and the shorter the duration of infertility before investigation, the greater will be the possibility for a cure. Industrial occupations permitting women to come in contact with roentgen rays or toxic chemicals such as lead and mercury may decrease ovarian function. History of frigidity, dyspareunia or vaginismus

may indicate local vaginal lesions or psychosomatic problems. Too frequent coitus may result in male infertility. The ovum may escape fertilization when coitus is infrequent. History of mumps, vaginitis, gonorrhea, syphilis, malaria, tuberculosis, diabetes and foci of infection may preclude defective gametogenesis. Previous operations, particularly in the pelvis, and specifically appendectomy may predispose to tubal obstruction by adhesions. A complete menstrual history with particular emphasis on regularity, amount, duration, pain, occurrence of midmenstrual bleeding, and vaginal discharge is necessary.

A general physical examination may uncover conditions such as heart disease, tuberculosis and diabetes, which may in themselves make pregnancy and further investigation undesirable. Endocrine dysfunction is noted in 30 per cent of some sterility studies.² Hyperthyroidism, hypothyroidism and hypo-ovarianism may be determined in the routine physical examination.

A careful pelvic examination must attempt to rule out congenital abnormalities of the female generative tract. Local infections in the vagina such as trichomoniasis, moniliasis and cervicitis are noted. Displacements of the uterus, new growths in the uterus or adnexa and evidence of previous adnexal infection are all of great importance in determination of the future course of treatment.

Laboratory examinations should include a red blood cell count and a hemoglobin estimation, complete urinalysis and, in some instances, determination of the basal metabolic rate or blood cholesterol.

Further examination of the female is not indicated until the adequacy of the male factor is established. Thirty to 50 per cent of the male partners are found to be deficient.³ In my practice the latter figure is more accurate. The sperm specimen may be obtained by masturbation or coitus interruptus, and in either case should be preceded by five days' abstinence. It is kept in a tightly sealed container to inhibit metabolism and is examined as soon as possible. Examination is sim-

¹Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 11, 1949.

ple and can be done by anyone who can do a simple blood count. The ejaculate is measured, the usual amount being 2 to 4 cc., and its consistency is noted. It should be liquid after standing. Marked viscosity is an indication of prostatitis. A count is done by drawing the semen up to the 1 mark in the white blood count pipet and filling the chamber with a saturated solution of sodium bicarbonate and 1 per cent phenol. After thorough mixing, one half of the mixture is discarded, and the remainder is flooded over the well of the ordinary counting chamber. The total count of five blocks in the red blood cell field is divided by two and six ciphers added to obtain the number per cubic centimeter. The presence of abnormal forms and evidence of infection are noted. Percentage of motility is determined by examining a drop of semen under the high dry objective. It is impossible to establish a definite level below which a man is infertile. It is believed, however, that the count should not be below 60 million, with at least 50 per cent motile after two hours, and no more than 10 per cent abnormal forms.³ One must also be careful not to condemn a man on a single examination. Two or three are made, lest his pride be shattered prematurely.

If the husband meets expectations, examination of the wife may proceed. Evidence of and the time of ovulation are determined by the basal body temperature. Temperatures are taken upon awakening in the morning and are recorded on an appropriate graph. A rise of one to two degrees is noted ten to sixteen days after the onset of the menses in the ovulating patient. The elevation continues until the menses recur, when the temperature drops simultaneously. This record is made for two to three months in order to obtain an average time of ovulation. The anovulatory patient will show no change in temperature levels. Vaginal smears, endometrial biopsies and estrogen progesterone assays offer little more information than does the basal body temperature.⁴

Tubal patency is determined by insufflating the tubes, preferably with carbon dioxide, five to seven days after the menses, coitus being forbidden to prevent an abortion. This procedure is done in the office, and the only equipment necessary is a cervical cannula and tenaculum, a small tank of carbon dioxide, a sphygmomanometer and rubber tubing. The patient is given 1/150 grain of atropine to aid in release of tubal spasm. The instruments are sterilized, and the cervix is prepared with iodine and alcohol. Carbon dioxide is used

rather than air since it is quickly metabolized. The pressure is not carried above 200 mm. of mercury. In most normal cases patency is evident between 60 and 130 mm. Spasm is indicated with patency at high levels. Patency is determined by observation of the mercurial fluctuations, auscultation of the lower part of the abdomen, and the presence of shoulder pain in the erect posture.

If patency is not established, repetition of the same procedure with the use of a roentgen ray opaque medium makes available visual evidence of patency or of the site of obstruction. Deaths have been reported from oil embolism when lipiodol was used. There need be no such accidents if an assimilable substance such as visco-rayopake or skiodan acacia is substituted. The latter is absorbed within fifteen minutes; so pictures must be exposed immediately. Although they are not as sharply outlined, there is no oily residue to remain indefinitely in the pelvis.

Determination of the nature of the cervical secretion is accomplished by testing with litmus paper and noting its viscosity. It is normally alkaline. The mucus is usually tenacious throughout the cycle with the exception of the period of ovulation when it is liquified. Huhner's test is of interest in testing compatibility of vaginal seminal fluid. Postcoital aspiration from the seminal pool and examination under the microscope will reveal the extent of mobility and motility of the sperm. A poor specimen indicates great acidity of the vagina or an inherent nutritional or physiologic deficiency in the spermatozoa. The Miller-Kurzrok lytic test is carried out by placing a drop of cervical secretion and semen on a slide and dropping a cover glass over the mixture. It is then possible to note the ability of the sperm to penetrate cervical mucus. Inability to do so is indicative of endocervicitis or primary seminal deficiency.

At the conclusion of such an investigation, it should be possible, in most instances, to tell the patients just why they have had no children and what they might do about it, and one might hazard a guess as to the chance of a successful result. In some cases the couples are advised that further treatment is not indicated, and adoption is suggested.

Treatment

Treatment may be divided into four categories: (1) general. (2) correction of ovarian imbalance, (3) treatment of faulty reception of sperm, and (4) treatment of male inadequacies.

Nutritional deficiencies in both partners must be corrected. Obesity and malnutrition are to be remedied. Sexual behavior is to be regulated. Abstinence is advised in order to prevent seminal depletion except during the period of ovulation, when daily coitus is recommended. Hypothyroidism is corrected with thyroid extract.

Hypofunction of the secretory activity of the anterior lobe of the pituitary body is primarily responsible for some of the endocrine sterilities, particularly since the functioning of the genital tract is largely dependent upon ovarian hormones influenced by pituitary stimulation.

Response to gonadotropic therapy can be effected, first, if the character of the gonadotropin is such that it will have the potency of complementing the pituitary deficiency which exists in these cases, and secondly, if the ovary has the ability to respond to such a stimulus.

I have had no success with gonadotropes, but I have seen many patients who became pregnant after long periods of anovulatory menses. Wolfe and Neigus,⁸ using varying doses of equine gonadotropin during various periods of the menstrual cycle, were unable to find evidence of ovulation in 22 patients operated upon. Although the granulosa and theca components of the maturing follicle are stimulated, it is likely that the gonadotropes now available are not capable of inducing ovulation in the human female.

Stimulative doses of roentgen rays to the pituitary body and ovaries are sometimes indicated.⁹ For the pituitary body, three treatments of 80 r are alternated to the right and left sides for a total of 240 r. For the pelvis, three treatments of 100 r are alternated to anterior and posterior ports until 300 r is given.

Treatment of faulty reception of sperm involves correction of cervicitis, cervical stenosis, removal of cervical polypi, and the clearing up of vaginal infections by the usual methods. Precoital alkaline nutritive douches are of value in producing a receptive environment for sperm, particularly if the Huhner test gives positive results. Suspension of the uterus is rarely indicated if tubal patency is demonstrated. Partial or complete tubal obstructions are the underlying factor in 50 per cent of the cases. Tubal insufflation alone frequently relieves the obstruction. In persistent obstructions due to previous salpingitis, diathermy or pelvic iontophoresis with mecholyl will occasionally surprise one by reducing exudates. Subsequent insufflation may reveal patency.

Salpingostomy and tubal implantation are successful in 15 per cent of some series.^{7a} The former is used for fimbrial occlusions. The clubbed fimbria is opened, and a cuff is reflected. To prevent closure of the opening until the edges have healed, various materials are used. Gepfert^{7b} employed allantoic membrane. Others reported using sulfathiazole powder⁸ and glucose sticks.⁹ I have delivered one patient whose pregnancy occurred after an ostium was made in the middle third of the tube and approximated to the ovary. Johnston¹⁰ described this technic. In the implantation technic for cornual obstructions, the occluded portion of the tube is excised and the proximal end reimplanted into a new cornual opening made by a common cork borer. D'Ingianni¹¹ devised a stainless steel cannula to prevent closure of the ostium. Tubal patency is demonstrated at operation by insufflation with a cannula in the cervix. Patency must be maintained by repeated gas insufflation for two or three months. Both operations increase the risk of tubal pregnancy by impeding the progress of the fertilized ovum, from impaired ciliary physiology or isthmic obstruction. The patient must be aware of the probably poor prognosis before surgery is instituted.

The treatment of male deficiencies is especially disheartening. The use of vitamin E and gonadotropic hormone has occasionally resulted in elevation of the count. Planned coitus is advisable to maintain the highest levels. In the remedy of poor nutritional states, the use of thyroid is sometimes beneficial. Local genital infections must be removed.

A word about artificial insemination. I personally think that it is decidedly preferable to satisfy a woman's longing for motherhood with a child of known value rather than to adopt a child whose background might be questioned. One must have the written consent of both husband and wife, and any children born from such a union should be adopted by the husband. Insemination is done on a proved fertile female by a selected donor twice each month at the period of ovulation. The donor must be unknown to the couple and vice versa. He must be in good health, with normal sperm and of similar coloring to the husband.

I should like to mention here and condemn the use of intracervical contraceptive pessaries, too vigorous cauterization of the cervix and unnecessary pelvic operations such as salpingectomy and oophorectomy in mild chronic salpingitis in the fertile woman. These procedures are frequently the

cause of irremediable sterility.

Conclusion

In conclusion, I believe that an adequate, thorough investigation should be made in all sterility problems and that the proper diagnosis should be determined prior to the institution of treatment. Only in this manner can the incidence of barrenness be reduced.

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Discussion

DR. EDWARD V. POLLARD, St. Petersburg: In the beginning, I should like to compliment Dr. Ellingson on the thorough and efficient manner in which he has handled this interesting subject. In discussing a paper of this type it is customary and desirable to take issue with the author whenever possible. I am afraid it will be difficult to do so in this case because the subject has been so adequately covered.

There are, however, a few points which I should like to emphasize. As Dr. Ellingson has stated, it is a common occurrence to have a patient report for a sterility investigation who has seen numerous doctors and has never been adequately investigated. I believe that these patients are entitled to a thorough investigation or no investigation at all. Too many people have spent thirty

minutes in a doctor's office and have been told that there is no reason why they cannot have children. This treatment is unfair to the patients. They will feel that they have had a thorough investigation until they actually get one. After they have had a complete investigation and see how extensive such a procedure is, they will feel that the other doctors have been unfair. I should like to emphasize that this entire investigation is an office procedure and that the Rubin test should not be done under anesthesia.

There are a few points that I should like to mention in reference to therapy. As far as I am personally concerned, I believe that the most effective therapy is the investigation itself. The insertion of the cannula into the cervix, the endometrial biopsy with the section curet, the tubal insufflation, and the basal temperature chart increase the chances of pregnancy more than all other measures. The use of equine gonadotropins and estrogens has been disappointing.

In the event that fertilization occurs and the individual patient does not have adequate progesterone effect manifested in the endometrium, premenstrual progesterone may be of value in aiding implantation.

Salpingograms are definitely of value in deciding whether or not surgery is indicated and are also valuable in advising the couple with reference to the prognosis. The most valuable part of a thorough sterility investigation lies in the fact that it gives the doctor the necessary information to advise the patient with reference to the continuation of her efforts to become pregnant, or to state whether or not he thinks pregnancy is so unlikely that she should proceed with the arrangements for adoption. One should be very skeptical in making a positive statement that a patient can never have a baby. We have all delivered many patients after they have been definitely assured that pregnancy was impossible. I make it a practice never to make the positive statement that pregnancy is impossible.

DR. FREDERICK H. FALLS, Chicago: Dr. Ellingson has covered the subject of his address thoroughly and I agree with him that an orderly investigation of the sterile couple is of the greatest importance to prevent discouragement from inadequate examination.

I have not found that taking the basal temperature has added much to the knowledge of the time of ovulation. I believe that too many other factors may cause a slight rise in temperature which may be misinterpreted. I therefore use the midmenstrual period, namely, the fourteenth day of a twenty-eight day cycle in estimating the time of ovulation. On the other hand, I think that a study of the basal metabolic rate in sterile women and in their husbands is of considerable clinical importance, as was shown by Litzenberg of the University of Minnesota and others. He found that a low basal metabolic rate was frequently present in sterile women and that sterility was overcome when this was brought up to normal by thyroid therapy. Subsequently the sterility was noted until the basal rate was again raised by taking thyroid.

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Industrial Dermatitis in Florida

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Dermatitis is the major occupational disease problem in Florida, as is demonstrated by the fact that the 946 claims for compensation for industrial dermatitis constitute 71 per cent of all the occupational disease claims for the year 1948. The nature of the dermatitis problem among industrial employees in this state is shown in table 1.

Table 1.—Claims for Occupational Dermatitis in Florida, Jan. 1, 1948 — Dec. 31, 1948

Alkali	255
Solvents and oils	121
Other chemicals	125
Fruit	117
Larva migrans	116
Fungus	77
Plant	40
Parasite	10
Actinic	2
Other	83
Total	946*

*Statistics by courtesy of the Florida Industrial Commission.

Causes

The most frequent cause of industrial dermatitis is some form of alkali, examples being cement, lime and soap. Alkali has two physiologic effects on the skin; first, it softens and dissolves the outer layers of the epidermis, and second, it removes the natural skin oils by combining with them to form soaps. Thus, the skin which has been exposed to excessive amounts of alkali becomes thin and hard and tends to crack. As might be expected, alkali dermatitis is common among brick layers, concrete workers, janitors and dishwashers. Control of alkali dermatitis is admittedly difficult on many construction jobs where adequate washing facilities are usually absent. Contrary to what one might expect, it is not commonly observed among men engaged in cement manufacturing, because cement production plants generally provide excellent protection for their employees.

Solvents and oils constitute the next largest group in the causation of industrial dermatitis. This classification includes gasoline, kerosene, lubricating oils and greases, turpentine and all the

other materials used in such operations as degreasing, dry cleaning and paint manufacturing. One physiologic action of oils and solvents is to dissolve out the skin oil. Another is the formation of plugs in the hair follicles resulting in comedones and occasionally furuncles. Exposure to oils and solvents occurs among machine operators, garage and petroleum workers, and dry cleaners. Control in this form of dermatitis is usually easier than in the alkali type because most of the exposed men work in established locations where washing facilities can be provided.

Fruit dermatitis, which is seen almost entirely in the citrus sectionizing industry, is of two types. Fruit peelers are subject to an acute dermatitis from contact with d-limonene in the peel. The lesions are somewhat like those of poison ivy. In fruit sectionizers, the disease is more chronic in type. It is characterized by erosions of the skin around the finger nails and in the webs of the fingers. Occasionally, the finger nails are lost. As yet, the exact cause of the sectionizers' dermatitis is not known, but probably the most important factor is the constant wetting of the skin with the citrus juice, which contains citric acid in solution.

Larva migrans (creeping eruption) poses another problem. As Dr. Kirby-Smith¹ of Jacksonville demonstrated over twenty years ago, its cause is the cat and dog hookworm known as *Ancylostoma braziliense*. This hookworm penetrates the human skin as far as the basal membrane and then moves laterally. Its presence gives rise to intense itching, which is usually followed by a secondary infection of the skin. Since this organism prefers to live in damp, shaded soil, the chief exposures are in men who work under houses, for example, plumbers, electricians and pest exterminators. It is possible to sterilize the soil by the use of ethyl bromide or concentrated salt solution, but both these methods have disadvantages which militate against widespread use. The most promising suggestion of recent origin is the application of calcium cyanamide at the rate of about 1 pound for 20 square feet. It is expected that this method will be tried out in Florida sometime this year.

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Diagnosis

The diagnosis of an industrial skin disease presents many problems. First, there should be a history of industrial exposure to a known irritant. The dermatitis should occur within a reasonable interval after exposure. The lesions tend to improve upon removal from exposure and to recur upon returning to employment. Most cases of industrial dermatitis begin with erythema and pruritus. The later manifestations are seldom characteristic enough to identify the causative agent or to differentiate them from many other skin diseases which are not industrial in origin. In some cases of sensitization, the patch test may be used to identify the cause of the dermatitis.

Prevention

Before discussing prevention, it should be pointed out that the human skin has certain defenses against irritation and certain weaknesses that favor invasion by industrial irritants. The chief defensive structure is the corneous layer of the epidermis. The skin is waterproof but not proof against oils and solvents. The sweat dilutes some irritants while the sebum neutralizes alkali to a limited extent. The normally acid reaction of the skin is a partial defense against alkali. Useful as these protective factors are, they must often be supplemented.

The vulnerable points in the skin are the openings of sweat glands and hair follicles. Both these structures pierce the epidermis and thus may permit comparatively deep penetration by irritants. Similarly, skin wounds or abrasions may act as breaches in the defense mechanism.

The first principle in prevention of dermatitis is to avoid contact of the skin with irritating materials. This may be done by impermeable clothing such as gloves, boots, aprons, hoods, or even complete suits of some material like rubber or Koroseal. Impermeable clothing gives effective protection in many cases, but it is uncomfortable to wear in hot weather and may interfere with the performance of work. Instead of protective clothing, use has sometimes been made of protective ointments. These may be satisfactory for short periods of exposure, but they are easily rubbed off by contact with tools and materials handled. Another method of protection is to keep the potentially hazardous materials in enclosed systems of tanks and pipes through which they are moved by pumps. This procedure works well in the relatively few instances in which it can be employed.

The other method of prevention is to supplement the natural defenses of the skin. The first line of defense is to have employees examined before they go to work. It is unfair both to employee and employer to expose any person who already has a skin disease to a hazard which may aggravate his pre-existing dermatitis. Also, it is important to have immediate first aid for every skin injury. The first treatment of all occupational dermatitis should be with some soothing application. In some of the employees there may be evidence of an irritation within a short interval after going to work, but if proper medical care is given, in many cases the skin will harden and these employees will have no further trouble. Another particularly important protective measure is the provision of a plentiful supply of hot water and mild soap so that foreign material can be removed from the skin as soon as possible after contact. Washing facilities should be plentiful and easily accessible. A good grade of soap should be supplied. Employees should be encouraged to make use of the washing facilities as much as possible. Sometimes it is advisable to provide workers with uniforms which can be washed and changed daily. In many cases it is advisable to furnish employees with some cream or other oily substance which can be used to replace the natural oils lost as a result of exposure to irritants. For this purpose the best material is some form of lanolin.

Even with the best of present day knowledge, it is often extremely difficult to prevent the occurrence of industrial dermatitis. It is necessary to know everything possible about the nature of the agents which cause disease. It is likewise important to provide all possible protective measures. In addition, it requires constant intelligent supervision and persistent educational efforts to lead the employees to avail themselves of the protective measures provided. Only in this way can one look forward to a progressively effective control of industrial dermatitis.

Summary

The nature of industrial dermatitis, major occupational disease problem in this state, is reviewed, and the most frequent causes, alkali, solvents and oils, fruit and creeping eruption, are discussed. Diagnosis and prevention are also discussed.

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Diagnosis and Early Treatment of Poliomyelitis

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The present discussion is based on experience in the diagnosis and management of patients with acute poliomyelitis at the Grady Memorial Hospital in Atlanta. There were 225 cases of acute poliomyelitis reported in Georgia during 1948, an incidence of 6.9 cases per 100,000 population. Of this number 123, or 55 per cent were observed at Grady Hospital.

Diagnosis

Some of the problems encountered in the diagnosis of poliomyelitis are illustrated by experience with patients referred to the hospital as possible cases of poliomyelitis. Twenty-six patients, or 16 per cent, of a total number of 159 did not have poliomyelitis. The diagnoses in these patients included rheumatic fever, scurvy, trauma to muscles, tick paralysis, infantile palsy, infectious polyneuritis, sickle cell anemia, hysteria, cord tumor, intracranial neoplasm, bacterial meningitis, mumps encephalitis, lymphocytic choriomeningitis, and encephalitis of unknown etiology. It is apparent, therefore, that polio may be confused with a wide variety of conditions. The occurrence of tick paralysis in this area is of particular interest in relation to the diagnosis of poliomyelitis and has been recently reported.¹ In tick paralysis there is usually no fever, spinal fluid is normal, muscular weakness is diffuse and bilateral, muscle spasm is absent, and there is little or no stiffness of the back or neck.

The diagnosis of poliomyelitis is almost entirely dependent on clinical findings. Specific diagnostic tests, which are available for certain other virus diseases, have not proved to be of practical value in the diagnosis of poliomyelitis. Virus may be isolated from the stools or throat washings of patients by inoculation of monkeys, but the interpretation is difficult because of the widespread occurrence of virus in the stools of apparently healthy persons during an epidemic period. Neu-

tralization tests with mouse-adapted strains of virus have not been of value in diagnosis.

Spinal fluid examination is the most helpful laboratory aid in the diagnosis of poliomyelitis. The fluid usually contains an abnormal number of cells varying from 10 to 500 cells per cubic millimeter. In the patients in this series 65 per cent had cell counts of less than 100 and 17 per cent less than 20 per cubic millimeter. The predominant cells are usually lymphocytes, but early in the disease polymorphonuclear cells may be present in as high as 60 per cent of the cells. The total protein is usually increased (60 to 125 mg. per hundred cubic centimeters) and persists for some weeks after the cell count has returned to normal. The spinal fluid sugar and chlorides are within normal limits.

Little difficulty is ordinarily encountered in the diagnosis of acute paralytic poliomyelitis. A febrile illness associated with patchy involvement of the muscles (flaccid paralysis, weakness, spasticity, tenderness, incoordination), together with an increase in mononuclear cells and protein in the spinal fluid, is pathognomonic. The abortive and nonparalytic types of poliomyelitis, which apparently far outnumber the paralytic, often present difficult diagnostic problems. The evidence seems clear that the majority of poliomyelitis infections do not produce symptoms or signs referable to the central nervous system. The onset of illness may simulate a mild infection of the upper part of the respiratory tract or gastrointestinal disturbance. In a large number of patients the disease does not progress beyond the initial nonspecific illness. There are no signs of involvement of the central nervous system, and examination of the spinal fluid gives negative results. In a smaller percentage of patients varying degrees of spasm and pain in the muscles of the neck, back and posterior thighs are observed. Abnormal spinal fluid findings are usually noted at this stage. Here again the disease may terminate without detectable involvement of the muscles.

The bulbar type of poliomyelitis is associated

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with paralysis of the cranial nerves and involvement of the respiratory and circulatory centers. One or more of the motor cranial nerves may be affected, causing facial paralysis, lid lag, strabismus and paralysis of the palate, pharynx, tongue and larynx. With involvement of the respiratory center there is anxiety, restlessness, increasing pulse rate, and variations in the rate and depth of respirations. Involvement of the circulatory center is manifested by a rapid pulse (150-200), which is irregular and thready, and a decreasing pulse pressure which may be as low as 10 mm. of mercury. The bulbar type of poliomyelitis may occur alone or in combination with the spinal type. In our group of patients 22 per cent showed bulbar manifestations. The encephalitic type of poliomyelitis is occasionally observed in which there may be hyperexcitability, personality changes, confusion, delirium, muscular tremors and twitchings, somnolence and coma.

The commonest symptoms presented by the patients in this series on admission to the hospital were, in order of frequency: fever, muscular weakness, headache, irritability, nausea and vomiting, stiff neck, muscle pain, malaise, dysphagia, dysphonia, sore throat and urinary retention. In general the diagnosis of poliomyelitis was unlikely if the following were present: a febrile illness continuing longer than a week or ten days; a loss of sensation; convulsions unless due to anoxia resulting from respiratory failure; visual disturbances; a spinal fluid cell count of over 500 cells, which if predominantly lymphocytes suggests mumps, herpes, or lymphocytic choriomeningitis virus infection; a spinal fluid protein above 150 mg. per hundred cubic centimeters, which raises the question of infectious polyneuritis; spasticity with a positive Babinski sign; a diffuse symmetric or progressive weakness; and localized tenderness such as occurs in trauma, arthritis, bursitis and acute osteomyelitis.

It is interesting to note that 36 per cent of the patients in our group of 123 were over 12 years of age and 12 per cent were over 21 years of age. There were 2 fatalities, both occurring in adults 24 and 25 years of age, respectively.

Treatment

No specific antibiotic or chemotherapeutic agent has been of value to date in the treatment of poliomyelitis. Treatment of the acute stage of

poliomyelitis is, therefore, symptomatic and supportive. This involves bed rest, adequate diet and good nursing care. Muscle tenderness and pain are relieved by proper positioning and heat usually in the form of hot packs. It is important to support paralyzed extremities properly in order to prevent deformities. Sedatives and analgesics are contraindicated because of possible respiratory failure. Parenteral administration of fluids is not advocated unless it is needed to maintain adequate fluid and salt balance or in patients with pharyngeal weakness or paralysis.

Bulbar poliomyelitis presents an immediate hazard to life and severely taxes the skill of the clinician in treatment. Involvement of the respiratory or circulatory centers carries a grave prognosis. Oxygen is given, usually by nasal catheter, and stimulants (caffeine) as indicated. It is most important to keep the throat clear of secretions by postural drainage and suction. Tracheotomy appears to be only rarely indicated and must be considered in those patients with obstruction of the airway that cannot be controlled by the ordinary procedures. No food or liquids are given by mouth to patients with pharyngeal involvement. Sulfonamides and penicillin are used for the control of respiratory infections. Paralysis of the intercostal muscles and the diaphragm, due to damage of the anterior horn cells of the cord, may also cause respiratory failure. The respirator is of great aid to these patients. Moist heat is also used to relieve spasm of the muscles of the back, thorax and abdomen, which may be interfering with respiration.

Summary

A series of 123 cases of acute poliomyelitis, representing 55 per cent of the cases reported in Georgia during 1948, is discussed. The age of the patients, symptoms in order of frequency, problems of diagnosis and differential diagnosis, and treatment are discussed.

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ABSTRACTS OF MEDICAL ARTICLES

THE VENEREAL GRANULOMAS: A COMPARATIVE STUDY OF THESE DISEASES IN FLORIDA. By Wesley W. Wilson, M.D., South. M. J. 41:412-419 (May) 1948.

A study of granuloma inguinale, lymphogranuloma venereum and chancroid occurring in Florida during the period 1942-1947 is presented. A series of 233 cases is presented in which these diseases were evaluated. For this five year period, averages for the entire United States and for Florida show that 12.4 per cent of the cases of granuloma inguinale occurred in Florida.

It is concluded that laboratory studies and intradermal skin tests have their limitations in the diagnosis of diseases of this group, but they play a very important part in the differential diagnosis.

In regard to therapy, it is observed that penicillin has no specific antibiotic action on the etiologic agents in these three diseases in so far as clinical evaluation is concerned. Streptomycin is regarded as the most encouraging form of treatment for granuloma inguinale; the rapid healing effected not only justifies the cost of this drug but also aids in the control of this disease. In this series sulfathiazole was the drug of choice in the medical treatment of chancroid and lymphogranuloma venereum.



MODIFIED IRRIGATING SOLUTION FOR TRANSURETHRAL PROSTATIC RESECTIONS: A PRELIMINARY REPORT. By T. Allen Dees, W. Dean Steward, Edward F. Meares and Louis M. Orr. J. Urol. 59:212-214 (Feb.) 1948.

A preliminary series of 10 consecutive cases of prostatic resection is reported in which a glucose-insulin irrigating solution in the ratio of 1 unit of crystalline zinc insulin to 4 Gm. of glucose was employed. Because insulin has long been used to "cover" the introduction of large amounts of glucose intravenously, the authors believed that the addition of insulin to the glucose irrigating solution might help prevent the excessive rise in blood sugar. Excessive elevations of blood sugar did not occur in these cases, and they concluded further study of glucose-insulin irrigating solution is warranted.

CONGENITAL EXTRINSIC DUODENAL OBSTRUCTION IN THE NEW BORN, REPORT OF TWO CASES. By Joseph S. Stewart, M.D. South. Surgeon 14:15-33 (Jan.) 1948.

Causes for the strikingly high mortality in cases of extrinsic duodenal obstruction in the newborn are, in the opinion of the author, delay in diagnosis in particular and also inadequate surgery. He believes that unfamiliarity with the peculiar pathologic conditions present in these cases, associated as they are with abnormalities in rotation, appears to account for both causes. Accordingly, he presents a well illustrated review of embryologic stages of rotation of the intestines and in particular of the midgut in order to clarify the anatomic arrangement of the intestines when there is interference with normal rotation.

In addition to focusing attention on the unnecessary high mortality in congenital duodenal obstruction of the newborn and the relationship between abnormal embryologic development of the midgut and the surgical pathology found in obstruction, Dr. Stewart stresses the importance of delivering the intestines on to the abdomen as a technical step in the surgery of this type of obstruction, the diagnostic importance of vomiting without abdominal distention and the importance of the procedure described by Ladd and Gross in the surgical correction of duodenal obstruction. He reports two cases.



PENTOBARBITAL SODIUM—CURARE INDUCTION FOR ENDOTRACHEAL INTUBATION. By H. Carron, M.D., V. K. Stoelting, M.D., and S. C. Cullen, M.D. Anesthesiology 9:11-14 (Jan.) 1948.

The purpose of this article is to describe and discuss the use of pentobarbital sodium and curare intravenously for endotracheal intubation under direct vision laryngoscopy prior to nitrous oxide anesthesia. This method of induction for intubation has the following apparent advantages: (1) rapid induction of anesthesia, (2) lack of or minimal degrees of laryngospasm and ease of intubation, (3) absence of explosive hazard, and (4) rapid recovery from anesthesia.

THE BASAL METABOLIC RATE IN DIAGNOSIS. By Iva C. Youmans, M.D. South. M. J. 41:150-153 (Feb.) 1948.

In evaluating the worth of determining the basal metabolic rate in diagnosis, Dr. Youmans notes the frequent lack of understanding of this information and also its frequent neglect when it might be a valuable aid in therapy, not only in bringing to light high rates but also, in particular, instances of low metabolism. She observes that the technic of the test, while now simple in theory, may not be so in practice and mentions numerous technical difficulties.

In the series of more than 500 cases reported, there were comparatively few in which the basal metabolic rate was above 1. The great majority of these cases were of a gynecologic nature and were referred in many instances because of menstrual disorders. The ages of the patients ranged from 12 to 65 years. Many of the girls in the 10 to 20 year group had their whole outlook changed by thyroid therapy, and treatment with anterior pituitary extract and iron if indicated. In this group the basal metabolic rate was as low as -32 per cent and frequently it was -15 to -25 per cent. In the group whose ages were 50 years and above, the rate was as a rule well within the normal range. The greatest number of low rates occurred among those whose ages ranged from 20 to 50 years, the child-bearing ages and those of the menopause. Especially during these ages the author regards determination of the basal metabolic rate as important as the complete blood count or urinalysis.

Among some of the etiologic factors suggested by her observations she mentions: (1) acute infections; streptococcic sore throat, the acute exanthems, and others; (2) chronic infections; chronic tonsillitis, sinusitis; (3) possibly the sulfonamides; (4) tropical and subtropical climate; (5) diet; especially low meat diet, and reducing diets; and (6) heredity, perhaps a contributing factor.

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2:30 p.m.

Quincy, Monday, Oct. 24, 1949

Palatka, Wednesday, Oct. 26, 1949

Sebring, Thursday, Oct. 27, 1949

Ft. Lauderdale, Friday, Oct. 28, 1949

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Truman Loses, Medicine Wins Battle on Reorganization Plan

The defeat of Reorganization Plan No. 1 on August 16 assured American medicine and its friends an important victory for the commonwealth. At first, many people inside and outside of the Congress found it difficult to see the dangers in President Truman's plan, which purportedly was that of the Hoover Commission. They said: "Oh, let it go through." "It's a step in the right direction." "The President has followed the Hoover Commission recommendations." "Health and medical functions can always be taken out of the Welfare Department."

That line of reasoning, however, was shallow and fallacious, for President Truman's plan differed sharply in several of its important features from that of the Hoover Commission. Plan No. 1 not only did not reorganize the top-heavy, wasteful Federal Security Agency, but actually ran counter to one of the Hoover Commission's important recommendations, which specified as follows:

[The independent health agency to be created] should be headed by a professional career director general. Under the new plan he should report directly to the President, and should, in the nonmilitary Federal medical organization, be the highest ranking physician in the Government. The supreme medical importance of the position of the Director General should command, irrespective of all other considerations, the ablest medical and health administrator whose services can be obtained by the Government.

It was neither unexpected nor too surprising that President Truman should disregard these recommendations and should propose to leave health and medical functions in the Welfare Department. It was, however, both surprising and somewhat disconcerting that Mr. Hoover, urged under pressure to save part of his plan even though some of his strong recommendations had been

ignored, acquiesced at the last moment and wired Republican Senators to support the plan.

Ever since organization of the Federal Security Agency in 1939, there has been a steady encroachment by Social Security lay officials on the domain of health and medicine. Social Security is dominantly concerned with old age and unemployment insurance, old age assistance, aid to dependent children and aid to the blind. The personnel of the Social Security Administration consists of statisticians, analysts, social workers, economists, auditors, actuaries and clerks. Most of the time there has been only one physician on the entire staff of that organization.

On the other hand, the United States Public Health Service, which for one hundred and fifty years has been dedicated to the task of preventing disease and improving the health of the nation's people, directs its activities toward medical research, industrial hygiene, sanitation and the control of infectious diseases. In addition, it has developed cooperative programs with the states for control of venereal diseases, development of pure water supplies and improvement of sanitation.

If Plan No. 1 had gone into effect, health and medicine almost surely would have come under lay and welfare control, which would have marked the culmination of thirteen years' effort on the part of the Social Security Board to gain control of the Public Health Service. This, there can be little doubt, would have been a step toward a larger scheme to nationalize and socialize medicine in the United States—a step toward enactment of the much discussed compulsory health insurance program, a political issue of next year, which calls for

integration of all nonmilitary medical programs including medical education, research and Public Health activities under lay administrators.

We seem justified in our belief that if Plan No. 1 had been put into effect, medicine, with great difficulty, if ever, would have freed itself from political domination and control by lay officials who favor nationalization. The testimony of Oscar Ewing, Federal Security Administrator, on July 21 supports this belief.

The fact that, despite Mr. Hoover's expressed opinion at the last minute in favor of Reorganization Plan No. 1, 60 Senators including 23 Democrats and 37 Republicans, voted for S. Res. 147, against the plan, indicates that our lawmakers are listening to the majority of the articulate voters despite other odds, and it further indicates that they are not blindly following the leader.

The victory is a monument to the hard work and determination of many organizations, physicians and friends. The Association of American Physicians and Surgeons, Inc., of which able Dr. Robert E. S. Young is president, should be applauded and acclaimed. Dr. Young's statement of July 22, made before the Senate Committee on Expenditures in the Executive Department, was well organized and impressive. Dr. James Buckley, president-elect of the Oregon State Medical Society, spent almost a week in Washington, while many state societies sent delegations of doctors to the capital to do spadework with the Senators prior to the vote. Likewise, the American Medical Association, the state associations, county medical societies and individual physicians throughout the nation all should come in for their share of praise and credit.

Communications from this state to Florida Senators and Congressmen expressing opposition to the reorganization plan were comprised of at least 56 from lay groups and individuals, at least 11 from medical societies and individual members of the profession, and at least 2 long distance telephone calls to Florida Senators. Despite this effort, both of Florida's Senators voted against S. Res. 147, to sustain Reorganization Plan No. 1. In order to acknowledge a letter of July 25 and a telegram of August 10 from Dr. W. C. Payne, President of the Florida Medical Association, and by way of explanation of his stand in supporting the President's plan, Senator Holland wrote to Dr. Payne on August 11 and again on August 18. The Senator's chief point seemed to be that "... former President Hoover, when he appeared be-

fore the committee, recommended approval of Plan No. 1 as a step in the right direction" In a letter dated August 25, Dr. Payne replied:

I am sure I need not tell you that the members of the medical profession of Florida have always had the highest respect for you. Our association with you while you were Governor was, from our point of view, most cordial and pleasant. Our Medical Association could not have asked for any finer cooperation than we received from you.

The American Medical Association for sixty-five years has been advocating the formation of a Department of Health with a Doctor of Medicine with Cabinet rank as director. This, to us, is a problem of vital importance. So while I am disappointed and sincerely regret that you felt it your duty to vote opposite from our wishes on the President's Reorganization Plan, my faith and confidence in your integrity have not changed. I am sure I speak the sentiment of other members of my profession. We look forward to discussing medical problems with you in the future.

With cordial regards from the writer personally, I am
Sincerely yours,
W. C. Payne, M.D., President

Dr. Joseph S. Lawrence, director of the American Medical Association's Washington office, suggests that with regard to future developments there now are four possibilities:

1. Things can be left as they are.
2. The President can propose a new plan.
3. Senator Taft can advance his plan.
4. A bill can be drafted embodying the Hoover Commission's plan.

Some seem to think that although the reorganization plan has hit a snag, the first plan can be presented again with only a few changes and that eventually it will be approved. It seems somewhat likely that the administration will not compromise and that in the Congressional election campaign of next year, the Democrats can use this alleged Republican repudiation of Herbert Hoover as stumping material.

After a conference at the White House in late August between President Truman and Oscar Ewing, the report was substantially a case of "no comment."

Thus we should remain alert. One victory seldom wins a war. There is fighting ahead which will require the resources and ingenuity of our best warriors. But we are right, and we shall win.

"Utopia on the Rocks"

The Scripps-Howard newspapers recently sent to Great Britain their senior editor, Mr. E. T. Leech of the Pittsburgh Press, to study the vast scale social, economic and political schemes of a revolutionary nature which have gradually been established in that nation. By talking with many hundreds of people, reading the numerous British newspapers, visiting various plants and districts,

and studying official statements, this astute observer accumulated much data. Late in August there was released a series of stories called "Utopia on the Rocks," designed to give in simple terms his impressions of what is a complex situation—that of running a completely planned state under the forms of and obstacles presented by democratic government.

In the first of these articles, he reminded the reader that America has pumped more than \$6,000,000,000 into Great Britain by so-called loans and outright gifts since the war. Britain is costing United States taxpayers \$1,000,000,000 a year and wants still more. Probably we will never get back one penny of these sums, and we may not even bring about the economic recovery for which we spent this vast amount because the social and economic schemes now in practice and proposed by that country's Labor government are fundamentally unsound.

Nobody else on earth has greater guarantees of security than has the British citizen. The state starts serving him before he is born, during all his years it will continue to do so, and after his death it will provide for his burial and likewise for his family.

Yet today one of the most insecure of the world's people is this same British citizen. If he studies and thinks about such matters, he is worried, disappointed and fearful. The security which he seeks so passionately is always in the future. He lacks many things. Much of what he produces, particularly that of the best quality, is for export, not for him.

Nobody else on earth pays such heavy taxes as does the Briton, for 40 per cent of the whole British income goes for taxes. With what is left after taxes, there is little he can buy or own. Such things as buying a home, an automobile or any of our standard household appliances are, generally speaking, beyond the realm of possibility for him.

Every Englishman is constantly exhorted to work harder and sacrifice more. He lives in a world of slogans and appeals—a democratic substitute for the propaganda of dictatorships. He lives in a world of crises—labor disputes, financial dilemmas, shortages and fast changing regulations.

Sir Stafford Cripps—the man who runs British finances and whose name is heard more than any other in Britain—now is calling for greater austerity. Sir Stafford, who uses no meat, tobacco or strong drink, is "Mr. Austerity" to the British

public. Hence, Britons were surprised and nettled recently when, instead of using England's health plan, he went to Switzerland for his health and went through special allowance by Prime Minister Clement Attlee despite the strict rules which sharply restrict use of British money for outside travel.

The British health plan obviously is not free—except for tourists. They are entitled to any part which they can find and which they can wait long enough to obtain, while the British taxpayer, and now indirectly the American taxpayer, pays and pays and pays.

The United States can perhaps get more than value received for the vast sums of money already sent to Britain. England can provide us with priceless lessons of experience, if we will only study them. She can teach us that the social and political schemes on which we have already started or with which we now are flirting can be extremely dangerous. She can show us that the broad promises of our social demagogues are not valid.

The theoretically secure Briton today is most insecure, for the all-giving British government is going broke. There can be no security for a people whose government is insecure.

Penicillin Rivals Forge Ahead

So effective are aureomycin and chloromycetin in the treatment of a variety of infections that these new drugs have already earned their place as the greatest antibiotics to be discovered since penicillin. Also, these rivals have numerous advantages over the old reliable, which only a short while ago was the newest wonder drug. Obtainable in tablet form, they may be administered orally; micro-organisms do not develop resistance after their continued use, and side reactions occur rarely.

Having won acclaim in the laboratory stage, these newcomers are engaged in healthy competition for the crown of wonder drug of the year. They are still expensive, leaving penicillin both cheaper and more readily available. If, however, as reported, scientists have found a way of synthesizing chloromycetin, and if this method proves practical and economical, the remedy may before long be as inexpensive as aspirin.

Both of these antibiotics are effective against certain viruses, and also against many gram-negative bacilli and rickettsial organisms. Reports are now appearing of their use with encouraging

results in the treatment of a variety of diseases. They are effective in many types of urinary infection, in influenza, in Q fever and in diseases of the eye. In some of the diseases now being cured by penicillin they are useful.

Included in aureomycin's long list of achievements is prompt relief of symptoms and clearing of the lungs in primary atypical pneumonia. Results of its use in tuberculosis are as yet inconclusive. Aureomycin in combination with dihydrostreptomycin was used with spectacular success at the Mayo Clinic in 4 severe cases of undulant fever. Other research indicates this combination is of value in chronic brucellosis.

In 15 cases of eastern type Rocky Mountain spotted fever, a disease likely to claim one out of every five victims, chloromycetin gave excellent results. It shortened the course of the disease, and all patients survived though 4 were extremely ill. In 25 cases of scrub typhus fever and in 10 cases of early typhoid there was also prompt response to this new drug.

Which of these antibiotics is the better remains to be determined. Doubtless each has its special mission. Increasing availability of these new remedies should bring reports of their effectiveness in larger series of cases, thus determining their rightful place in the physician's armamentarium.

Make It Real

"Nothing is real until it is local," once said a great man. To be of value the truth about socialized medicine must be local. Are you localizing it? If not, you are being definitely unreal and losing your biggest opportunity to help your profession in its hour of need.

Patients should know how the Truman Administration's crusade for socialized medicine, politely called compulsory health insurance, will affect them personally. They are the doctor's public, and they constitute his best approach to the man on the street. What each physician tells his patient is the grass roots approach, the practical localizing appeal.

That so-called free medicine will not be free is a basic fact which should be impressed deeply upon the patient and the public at large. Employee and employer will be required to share equally a tax reportedly estimated currently at 3 per cent. Since the actual expense would inevitably be far

more than the deceiving official estimates, this percentage would climb appallingly, no doubt promptly becoming 5 or 6 per cent on each. In England, the cost for the first six months was approximately 60 per cent more than was provided in the plan. The employer must meet his half of the tax from earnings if his firm is to remain solvent. "We may anticipate then a 10 per cent tax on earnings. Dependable figures show that at present $4\frac{1}{2}$ per cent of the family income goes to pay for medical care. The result, therefore, will be that free medicine under these conditions, without regard to quality, will cost the average family with an income of \$3,600 a year about \$360, while now it costs \$180."¹

A second and even more important aspect should be made real, very real, to the patient. Socialized medicine would undoubtedly produce stagnation in the system that has made American medicine the best on earth. Bureaucratic domination is bound to affect the quality of care. A layman, quoted editorially recently in the Cleveland Plain Dealer and the New York Daily News, gives the picture graphically:

You don't have to listen to the perfectly legitimate objections of doctors and dentists (to state medicine) . . . ; all you have to do is to see the way it is working out in Great Britain.

I lived over there and saw it function. Thank the Lord, I didn't have to depend on it, for I could go to competent Army doctors. But I had plenty of friends who were forced to depend on it, for they had deductions for it taken out of their slim pay and couldn't afford to hire Harley Street specialists.

If what they got under socialized medicine was medical care and competent treatment of illness and disease, then I'm a Tanganyikan rhinoceros. The panel doctor's office was an assembly line of 50 patients crowded into the time and space it should have taken him to handle 10. He gave each of them scarcely more than a look and a promise—and often they got the wrong medicine in the rat race. Some of the offices were even unclean and some of the doctors were smelling high of drink, but what did they care? Their fees were guaranteed by the Government at so much a head.

And the poor patient, if dissatisfied, couldn't change doctors once he had signed up, without the permission of the doctor he didn't like or without three months for a government board to make up its mind. Meanwhile, he could make a choice between paying a competent specialist a stiff fee or dying slowly. One thing for sure, the socialized doctor would never cure him.²

Would Uncle Sam as a doctor be any less of a quack and charlatan than this picture paints Dr. John Bull as now being? This query in the New York Daily News is coupled with a plea for facts, not "hot air." Doctors, comments the New York

1. The Impact of State Medicine on the Patient, editorial, New Orleans M. & S. J. 101:450-451 (March) 1949.

2. More of the Same Advice Needed, editorial, New York State J. Med. 49:889-890 (April 15) 1949.

State Journal of Medicine, are in a position to realize the value to the tax-burdened citizens of this country of straight thinking, hard hitting editorial comment such as this, which says in language people can understand what doctors would say if they published newspapers.

Know the truth about this impending evil. Then localize it for your patients and your community. Make it real.

An Age of Age

Longevity is here. Statistics substantiate the claim that the populace is entering upon an age of age. Infants born today have an expected longevity of approximately 67 to 69 years, depending on whether they be boys or girls. Within the last half century the average length of life has been extended more than two decades, and there are now over ten million people beyond 65 years of age in the United States. But the coveted goal of longevity with continued vigor, usefulness and enjoyment of life is, unfortunately, attained by few.

Life is multidimensional. To make it rich and full, depth and breadth must go hand in hand with length. A vigorous and mature mankind, possible only with health, offers staggering potentialities. Wisdom and judgment, the fruits of time-acquired individual experience, are thus conditioned by age. The composite judgment and sense of values of groups and nations and peoples are but a measure of the maturity of the population from which they are derived. This maturing culture promises for the future a maturing mankind that should become wiser, finer, more tolerant. Herein may even lie the road to lasting peace.

Upon whom rests the responsibility for health in later maturity? Primarily, of course, upon each aging individual himself. Health, like esteem, must be earned. The life that is rich and full is not fortuitous; it involves self discipline in living and requires intelligence and effort in its maintenance. Medical science, medical practice, medical service schemes cannot present health to anyone.

Nevertheless, it is the responsibility of medical science and practice to discover the causative factors for the chronic progressive disorders of later maturity and the means of their prevention, and likewise to advise those who would stay well. There is no greater challenge before the medical profession today than the related problems of

senescence and of premature senility or of disablement from the endogenous, chronic, progressive, degenerative disorders. Furthermore, these problems will be much more urgent ten or twenty years hence than they are now for there will be millions more aging men and women vulnerable to the tragedy of prolonged progressive disablement and the hopelessness of uselessness.

Much is known which is not yet fully applied. Much more remains to be known. Scientific research into the many facets of health maintenance and construction is the cornerstone on which rests the hope of a more mature, and therefore doubtless a more peaceful, world. The task now is to create health to correspond with the duration of life.

Let's Be Ready for the Next Round

In rejecting President Truman's Reorganization Plan No. 1, the Eighty-First Congress served notice that the granting of wide powers to the President to streamline the executive branch of the federal government is not blanket authority to regiment medicine in the United States. Likewise, the approval of the six other reorganization plans submitted by the Chief Executive is evidence that the Congress is interested in economy and carrying out the recommendations of the Hoover Commission. In the editorial section of this issue of *The Journal* may be found an enlightening discussion of Reorganization Plan No. 1.

As reported previously in these columns, the proponents of compulsory health insurance have admitted that there is little hope of obtaining passage of any such legislation during the present session. They have also served notice that they will be back with new proposals in 1950. In fact, they blandly say that government-provided medical care will be a major issue in the coming Congressional elections. With medicine's "grass roots" campaign to carry the truth to the people now getting into high gear, this tactic can be made to boomerang. Now it becomes imperative that every doctor talk to his Congressman, and to the Senators, if possible, during the weeks following adjournment of the first session.

Doctors also have an opportunity to see that their hospital administrators and other officials are well informed. Out of Washington come persistent rumors that Administration supporters plan temporarily to ease up their efforts for compulsory medical insurance and concentrate on compulsory hospital insurance.

Medical District Meetings October 24-28, 1949

Dr. Russell B. Carson of Ft. Lauderdale, Chairman of Council, the eight councilors and the secretaries of the cooperating county medical societies have completed the programs for the annual Medical District Meetings, which will be held this year from October 24 through October 28.

In contrast to the annual convention, the fall meetings are literally taken to the members, being held in a city in each of the four districts. This excellent opportunity enables physicians to reap the benefits of these half day meetings without having to interrupt unduly the routine of their responsibilities.

The officers of the Association will bring pertinent information concerning activities on a state-wide scope that should be of particular interest to every physician. These stimulating messages are designed to keep the members in close contact with the activities of the Association. In addition, a well planned and diversified scientific program is offered for the enlightenment of general practitioners and specializing practitioners alike.

Printed programs will be mailed to all members of the Association. Each member is urged to attend as many of these medical district meetings as possible, and if the press of duties makes this impractical, to make it a point to attend the meeting in his district. The meetings will open at 2:30 p.m. on the dates specified below.

Monday, October 24, 1949

Quincy

Sawano Country Club

Address of Welcome, Merritt R. Clements, President, Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

"Multiple Small Bowel Intussusception," Nathan Arenson, Pensacola

Address (by invitation), "Consideration of the Pancreas in the Diagnosis of Upper Abdominal Diseases," Edwin H. Andrews, Gainesville

Wednesday, October 26, 1949

Palatka

Elks' Club

Address of Welcome, Grover C. Collins, President, Putnam County Medical Society

"The Nonfunctioning Gallbladder," Alphonsus M. McCarthy, Daytona Beach

"A General Practitioner's Care of the Prostate," A. Fred Turner, Jr., Orlando

Thursday, October 27, 1949

Sebring

Sebring Hotel

Address of Welcome, John A. Simmons, President, DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society

"Jaundice," Joseph C. Flynn, Tampa

Address (by invitation), "The Toxic Effect of Tetra-Ethyl Pyrophosphate (T.E.P.P.)," Garland M. Johnson, Ft. Lauderdale

Friday, October 28, 1949

Ft. Lauderdale

Trade Winds Hotel

Address of Welcome, Paul G. Shell, President, Broward County Medical Society

"The Pathology of the Female Urethra—A Review," Milton M. Coplan, Miami

Address (by invitation), "Observations on Digitoxin," Henry Fuller, Lakeland

After the scientific assemblies, addresses will be given at each of the four medical district meetings by:

Walter C. Payne, President

Herbert E. White, President-elect

Robert B. McIver, Secretary-Treasurer

Shaler Richardson, Editor of The Journal

Joseph S. Stewart, Chairman, Public Relations Committee

Eugene G. Peek, Chairman, Legislation and Public Policy Committee

Mr. Ernest R. Gibson, Supervisor, Bureau of Public Relations

At 5:45 p.m., refreshments will be served by the host societies. Dinner will follow at 6:30 p.m.

A. M. A. School Health Conference October 13-15

The Second National Conference on Physicians and Schools will be held at the Hotel Moraine, Highland Park, Ill., October 13-15. This movement is sponsored by the American Medical Association under the Bureau of Health Education, and the first conference, held in 1947, attracted representatives from about ninety agencies or organizations.

Participating will be representatives of state medical societies and associations, state health departments, state education departments and national agencies with an interest in school health. Some forty speakers and consultants of national prominence are to lead discussions concerning the

various aspects of school health services.

Since the conference is of vital concern to the medical profession, it is expected that the interest of the profession in the conference and the problems to be considered will be reflected in a large representation of state medical societies. Florida is fortunate to be represented by Dr. M. A. Lischkoff of Pensacola.

YOUR BLUE SHIELD

Close Affiliation with Blue Cross

In Florida, as in many other parts of the country, the Blue Shield Plan is operated jointly with the Blue Cross Plan for hospital care. These plans, although separate corporations with separate governing boards, are under one administration and have one common objective—to establish a means of removing the financial barrier to adequate hospital and surgical care and to provide maximum benefits at minimum cost.

The enrolment of members and the details of operation of each plan are carried out by the same field and office forces. Employees of one plan are employees of both. This arrangement is made possible through a special working agreement between the two plans, whereby each plan pays its proportionate share of the operating expenses based on the number of members enrolled in each plan. Such an arrangement serves to keep operating expenses of each plan at a minimum, so that it is possible for the plans to return an exceptionally high percentage of membership fees in actual benefits to members.

Blue Shield and Blue Cross are offered to the people of Florida as a complete hospital-surgical care package, and since the organization of the Blue Shield Plan in 1946, simultaneous enrolment in both plans has constituted 99 per cent of all group enrolment.

Physicians Hold Purse Strings of Both Plans

The close affiliation of these two nonprofit plans, the basic objective which they have in common, and the steadily increasing membership in these plans have placed an important responsibility on physicians. In reality, the physicians hold the purse strings of both plans, because it is the physician who determines and prescribes the services a patient needs. The successful operation of the Blue Shield and Blue Cross Plans has been due in large measure to the fact that the participating

physicians confine utilization of plan benefits to necessary care. This makes it possible to provide highly expensive benefits at the time they are actually needed by the patient. If physicians, generally, had not conscientiously fulfilled their duty, costs would have risen to a point where the plans could not have continued to exist. For example, it would have cost the Blue Cross Plans in the United States an estimated \$35,000,000 last year, if just one day of unnecessary hospital care had been prescribed for each Blue Cross patient. In the years Blue Shield and Blue Cross have been in operation, however, physicians have displayed the highest degree of professional discretion in serving the best interests of the plans and their patients.

Without the support and understanding of physicians, Blue Shield and Blue Cross could not have attained their present stature and importance.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

Cleland D. Cochrane of Daytona Beach, local Exchange Club
Odis G. Kendrick of Tallahassee, local American Legion Post
Francis T. Holland of Tallahassee, local Optimist Club
Howard G. Holland of Leesburg, local Rotary Club
Paul J. Coughlin of Tallahassee, local Rotary Club
Joseph S. Stewart of Miami, local Credit Women's Club
Howard G. Holland of Leesburg, local Junior Chamber of Commerce
Reuben B. Chrisman, Jr., of Miami, Dade Business and Professional Women's Club
Jerome A. Megna of Ft. Pierce, local Kiwanis Club
Frank G. Slaughter of Jacksonville, Keystone Heights Rotary Club
Arthur J. Henry, Jr., of Tallahassee, local Junior Chamber of Commerce

✍

PRACTICE FOR SALE: Growing north Florida town of 5,000. Grossed \$20,000 last year. Specializing. Write 69-26, P. O. Box 1018, Jacksonville, Fla.

✍

E. E. N. T. PHYSICIAN: Well trained; 38 years of age; excellent personality, wishes association with specialist or clinic. Write 69-28, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

Dr. Walter C. Payne of Pensacola, president of the Association, was guest speaker at the annual dinner meeting of the Munroe Memorial Hospital staff of Ocala in August. Dr. Payne was introduced by Dr. Eugene G. Peek, Sr.

Dr. Payne spent a half day at the Association's headquarters in Jacksonville on his way to Ocala and another half day on his return trip. He has officially visited the headquarters office on several occasions.

Dr. Robert M. Sasso of Lake City recently spent ten days in New York attending clinics.

Dr. James L. Estes of Tampa recently attended a clinic at the Emory Hospital, Atlanta, Ga.

Dr. Nelson M. Black, Sr., of Miami announces that Dr. Mariano C. Caballero has joined him in the practice of ophthalmology. Their offices are located at 703 Huntington Building.

Dr. J. Ralph Vallotton of Daytona Beach has been named by Governor Warren to the State Board of Medical Examiners to succeed Dr. Samuel G. Hollingsworth of Bradenton, whose term expired.

Dr. Edwin G. Riley of Bartow was the guest speaker at the weekly luncheon meeting of the Winter Haven Lions Club on August 5. He outlined the efforts of medical science in combatting infantile paralysis and related the history of the rise of polio epidemics in the United States.

Dr. Wilbur C. Sumner of Jacksonville recently spoke to members of the Jacksonville Exchange Club. His subject was "The Brighter Side of the Cancer Patient."

Dr. Jackson L. Bostwick of Jacksonville has begun a three year course in neurosurgery at the Mayo Clinic, Rochester, Minn.

Dr. James N. Patterson of Tampa has returned to his practice after receiving a course in hematology at the Michael Reese Hospital in Chicago.

Dr. Charles J. Roehm of DeFuniak Springs

has completed clinics in surgery at the Cook County Graduate School of Medicine in Chicago.

Dr. Warren W. Quillian of Coral Gables and Dr. Luther W. Holloway of Jacksonville, members of the faculty of the Southern Pediatric Seminar, Saluda, N. C., were lecturers at the organization's recent annual summer course. Dr. Quillian spoke on "Convulsive Disorders" and "Diarrheal Diseases." Dr. Holloway lectured on "Premature Care" and "Malignant Diseases of Infants."

Association members attending the course were Drs. Harold S. Agnew, Arcadia; Leo Batell, Tampa; Van B. Bennett, Jasper; Reddin Britt and Robert D. Harris, Jr., St. Augustine; Edgar E. Hitchcock and Charlotte C. Maguire, Orlando; Ruth W. Rumsey, Miami; Grayson C. Snyder, Blountstown; Herbert M. Webb, Jr., Wildwood.

Dr. James A. Craig of Naples was the speaker at the August 2 meeting of the local Lions Club. He spoke briefly on infantile paralysis as it is affecting the state and the nation.

Dr. Allen E. Kuester of Cocoa spoke to members of the local Kiwanis Club recently on the high death rate caused by heart disease.

Dr. Henry L. Smith, Jr., formerly of Jacksonville, has moved his offices to 400 North Adams Street, Tallahassee.

Dr. L. Roland Young, neuropsychiatrist of Daytona Beach, has accepted a position as Clinical Director of the East Louisiana State Hospital for mental diseases at Jackson, La.

BIRTHS AND DEATHS

Births

Dr. and Mrs. John N. Sims of Live Oak announce the birth of a son on Aug. 20, 1949.

Deaths—Members

Dr. E. Thomas Kinsey, Madison	July 25, 1949
Dr. Thomas K. Slaughter, Wildwood	July 27, 1949
Dr. William T. Elmore, Gainesville	Aug. 7, 1949
Dr. Harold F. Preston, Melrose	Aug. 17, 1949

Deaths—Other Doctors

Dr. Guy A. Longbrake, Ft. Myers	July 28, 1949
Dr. Harold W. Brann, Palo Alto, Calif	April 9, 1949
Dr. Daniel H. Griffith, Frostproof	June 2, 1949
Dr. Franklin A. Perkins, Boston, Mass	June, 1949

Medical Officers Returned

Dr. Wayland T. Coppedge, Jr., who entered service May 25, 1943, received his discharge on March 1, 1947. Dr. Coppedge's address is 1900 Boulevard, Jacksonville. He held the rank of Lieutenant in the Navy.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Fitzpatrick, Raymond J., Orlando
Fletcher, T. Bert, Jr., Tallahassee
Henry, Arthur J., Jr., Tallahassee
Spivak, Abraham H., Orlando

COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Charlotte-Glades

At the August 8 meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, which was held at the Simmons Hotel in Wauchula, Dr. Louis M. Orr, II, of Orlando was the guest speaker. He spoke on "Pyelonephritis," and also gave a report on "Actions of the House of Delegates of the A.M.A."

Members present included Drs. Harold S. Agnew, Henry P. Bevis, Isaac W. Chandler, Miles A. Collier, Merle C. Kayton, Charles H. Kirkpatrick, Gordon H. McSwain, Leldon W. Martin, Zaven M. Seron, John A. Simmons and Howard V. Weems. Dr. H. W. Martin and Dr. H. N. Rafferty of Sebring also were guests.

OBITUARIES

William Taylor Elmore

Dr. William T. Elmore of Gainesville died on Aug. 7, 1949, at the Veterans Hospital in Lake City. He had been in ill health for many years. He was 76 years of age.

Dr. Elmore was born on June 9, 1873, in Charleston, Miss., the son of Albert Rhett and Alexina Taylor Elmore. The family moved to Florida while he was a child. He was graduated from the University of the South Medical Department, Sewanee, in 1904. His internship was served at the Willard Parker Hospital in New York City.

He then moved to Jacksonville, where he opened offices for the practice of medicine. Dr. Elmore later became superintendent of the Duval County Hospital. At the onset of World War I, he volunteered for service in the United States Army Medical Corps, and was separated from the service as a major. Until his retirement two years ago, he served as medical officer for Company D, Second Battery of the Florida National Guard. He was a member of the American Legion.

Dr. Elmore was a member of the Alachua County Medical Society, an honorary member of the Florida Medical Association, and a member of the American Medical Association.

He was affiliated with the Episcopal Church.

Survivors include two sisters, Mrs. Alexina J. Gardner, Gainesville, and Mrs. James Haite, Auburn, Ala.; a brother, Thomas T. Elmore, Tallahassee; four nephews and three nieces.

Karl Winfield Ney

Dr. Karl W. Ney of Stuart died at his home on May 30, 1949. He was 64 years of age.

Dr. Ney became a resident of Florida only three years ago. At that time he retired from active practice, and moved to Stuart, where he continued to receive patients by appointment only.

He was born on Aug. 1, 1884, in Edinburg, Ind., the son of Dillard and Emma Ney. He was a direct descendent of historically famous Marshal Michel Ney of the French Empire under Napoleon, 1805-1815. Dr. Ney was graduated from the Louisville and Hospital Medical College in 1908 and began the practice of medicine in Louisville. In 1914 he became chief surgeon at the Presbyterian Hospital in New Orleans and was chief of surgery for the French Red Cross in 1915 and 1916. He served as a major in the medical corps of the United States Army from 1917 to 1921 and was senior officer for Neurological Unit I in the American Expeditionary Forces. Later he was chief of neurological service in United States General Hospital 3 in Colonia, N. J., and was affiliated with Army General Hospital 41 at Fox Hills, Staten Island.

Following military service, Dr. Ney was dean of Polyclinic Hospital, New York City, and was clinical professor of neurological surgery at the New York Medical College, Flower and Fifth Avenue Hospitals in New York City. The surgeon's chief interest was epilepsy, in which he did exten-

sive research. He also devised an operation for facial paralysis.

Dr. Ney was a member of the St. Lucie-Okeechobee-Martin County Medical Society and of the Florida Medical Association, a fellow of the American Medical Association and of the American College of Surgeons, and a member of the American Neurological Society. He also was an honorary life member of the Neurosurgical Hospital, Welfare Island, New York. He was affiliated with the Masonic Order and was a member of the Amateur Trapshooting Association. Dr. Ney was a member of the Episcopal Church.

Surviving him are his widow, Mrs. Enid T. Ney, and three children by a former marriage, Mrs. Preston Degraw Baldwin of Lake Hopatcong, N. J.; Karl W. Ney, Jr., of Texas, and Irving E. Ney of Bradenton.

Clarence Larimore Perry

Dr. C. Larimore Perry of Miami died at the Jackson Memorial Hospital on July 6, 1949, a few hours after he was stricken with coronary heart disease. He had spent a busy morning in the operating room and was starting afternoon office consultations when he was taken ill. Dr. Perry was 52 years of age.

He was born in Las Vegas, N. M., on Feb. 16, 1897. His father, a banker, died when his son was eight years old. With his mother, two brothers and two sisters, he moved to Delaware, Ohio, where he received his early education. During World War I, Dr. Perry served with the Signal Corps of the 30th Division until he was seriously wounded and gassed at Bellecourt. Following a long convalescence, he returned to the United States and received the Bachelor of Arts degree from Ohio Wesleyan University in 1921. After attending summer sessions at the University of Michigan School of Medicine and Rush Medical College, he entered the Ohio State University College of Medicine at Columbus, from which he received his medical degree in 1924.

Dr. Perry interned at St. Francis Hospital in Columbus from June to November, 1924, when he became resident physician at the Ohio Penitentiary Hospital, serving in that capacity until January, 1926. On April 1, 1926 he entered the Mayo Foundation as a fellow in surgery. His services included postoperative care, general medical and surgical diagnosis, regional anesthesia,

surgical pathology and surgery. He was surgical assistant to Dr. Charles H. Mayo, Dr. Fred W. Rankin and Dr. Stuart W. Harrington, and was first surgical assistant to Dr. James C. Masson. Dr. Perry was licensed to practice medicine in Florida and in Ohio in 1924 and in Minnesota in 1927.

Dr. Perry's career in Florida began in Miami in October 1929, soon after he left the Mayo Foundation. He became a member of the Dade County Medical Association at that time, and later served one term as president. He was a member of the Florida Medical Association, and a fellow of the American Medical Association and of the American College of Surgeons. This distinguished surgeon was also a member of the Southern Surgical Association, the Southeastern Surgical Congress, the Southern Medical Association, the Association of Resident and Ex-Resident Physicians of the Mayo Clinic, and the Phi Rho Sigma medical fraternity.

At the time of his death, Dr. Perry was senior attending surgeon in charge of a service at the Jackson Memorial Hospital, where he formerly was president of the staff. Also, he was senior attending surgeon and associate chief of the Department of Surgery at St. Francis Hospital in Miami Beach.

His contributions to medical literature were many and appeared in the *Annals of Surgery*, the *Southern Medical Journal*, the *Journal of the Florida Medical Association*, the *Bulletin of the Dade County Medical Association* and the *Bulletin of Jackson Memorial Hospital*.

He was a member of the Masonic Order and of the Shrine. Socially, he was a member of the Phi Gamma Delta fraternity, the Bath Club, the La-Gorce Country Club and the Committee of 100, Miami Beach.

On Dec. 8, 1922, Dr. Perry was married to Miss Bethena Elizabeth Townley of Asheville, N. C., who survives him. He also is survived by two daughters, Mrs. John E. Donalds, II, Arlington, Mass., and Miss Linda Perry, Miami Beach; his mother, Mrs. Fanny Larimore Perry, Granville, Ohio; two brothers, John W. Perry, Arlington, Va., and Eugene Perry, Ft. Wayne, Ind.; two sisters, Mrs. W. W. Shanor, Erie, Pa., and Mrs. William Huebner, New Rochelle, N. Y.; and one granddaughter, Linda Larimore Donalds, Arlington, Mass.

Major Edward Threlkeld

Dr. Major E. Threlkeld of Miami died suddenly on July 12, 1949, a victim of coronary thrombosis. He was 58 years of age.

Dr. Threlkeld was born on Aug. 27, 1890, in Kentucky. He attended the University of Kentucky and received his medical degree at the University of Louisville School of Medicine in 1919. Following his service in World War I and a two years' internship at the Louisville City Hospital, Dr. Threlkeld practiced medicine in Hazard, Ky. In 1925 he moved his offices to Miami, where he practiced continuously until the time of his death.

He had served as county physician and was a member of the examining board during World War II. Fraternally, he was affiliated with the Masonic Order, the Shrine, and the Benevolent Order of Elks. Dr. Threlkeld was secretary of the Dade County Medical Association in 1935 and 1936. He was a member of the Florida Medical Association and a fellow of the American Medical Association.

Surviving him are his widow, Mrs. Mary Campbell Threlkeld; a son, Major Edgar Threlkeld; three daughters, Ann Threlkeld of Miami, Mrs. Mary Doan of Alberta, Canada, and Mrs. Nancy Crane of Eastport, Me.

Nilo C. Pintado

Dr. Nilo C. Pintado of Miami died on June 11, 1949. He was 64 years of age.

He was graduated in 1908 from the University of Havana School of Medicine and Pharmacy. In 1910, he was licensed to practice medicine in Florida and began practicing in Key West. Dr. Pintado joined the Monroe County Medical Society in 1912 and served that organization as vice president in 1929. He was a member of the Florida Medical Association for thirty years.

In 1947, Dr. Pintado opened offices for private practice in Miami and became associated with the Cuban Consular Service there.

Thomas Kimball Slaughter, Sr.

Dr. Thomas K. Slaughter, Sr., of Wildwood died on July 27, 1949 in Halifax District Hospital in Daytona Beach after an illness of six months. He had entered the hospital on July 19, having previously been a patient in a New York City hospital. He was 73 years of age.

Dr. Slaughter was born on Oct. 15, 1875, at Indian Springs, Ga. He spent most of his childhood there and entered the University of Georgia in 1894. After his graduation in 1897, he was a pharmacist at Griffin, Ga., at Jacksonville, and also at Ocala where he was associated with the late Dr. William Anderson. Then he entered the Atlanta College of Physicians and Surgeons and received his medical degree in 1899. Returning to Florida, he practiced medicine in Oxford and Kissimmee before locating in Wildwood, where he practiced until illness caused his retirement.

Civically and fraternally, Dr. Slaughter was a leader in the Wildwood community. He was chairman of the Wildwood City Council, having served as a member for twelve years, and was a member of the Chamber of Commerce. He was a member of the Masonic Order, the Knights of Pythias, the Woodmen of the World and the Odd Fellows, and was a charter member of the Elks Club at Ocala. He was also a charter member of the Wildwood Lions Club.

Dr. Slaughter was physician for the Seaboard Railroad in Wildwood and was a member of the Railway Surgeons Association. He was a member of the Marion County Medical Society, a life member of the Florida Medical Association, and a member of the American Medical Association.

Survivors include his widow, Mrs. Eunice Slaughter; a son, Dr. Thos. K. Slaughter, Jr., of Daytona Beach; and two sisters, Miss Viola and Miss Fanny Slaughter, both of Jackson, Ga.

Luther Albion Hodsdon

Dr. Luther A. Hodsdon of Miami died on July 9, 1949 after an illness of seven weeks. He was 72 years of age.

Dr. Hodsdon was born on Dec. 4, 1876, in Boston, Mass. He was graduated from the Tufts College Medical School in Boston in 1898 and did

(Continued on page 242)

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postgraduate study at the New York Polyclinic and the New York Post Graduate Medical School before entering general practice in Boston.

In 1920 Dr. Hodsdon completed additional graduate work in ophthalmology at the Massachusetts Eye and Ear Infirmary. In 1921 he became associated with Dr. Benjamin F. Hodsdon in the practice of ophthalmology in Miami. He was a member of the staffs of the Jackson Memorial Hospital and the Kendall Hospital for many years.

Dr. Hodsdon was one of the founders of the University of Miami in 1925 and was the designer of the University seal which is still in use.

He was a member of the Dade County Medical Association and of the Florida Medical Association, and was a fellow of the American Medical Association.

Frederick L. Flynn

Dr. Frederick L. Flynn of St. Petersburg died unexpectedly on July 12, 1949, following a heart attack which occurred while he was making a call. He suffered from a chronic coronary ailment and had had a severe attack several years ago. Dr. Flynn was 40 years of age.

The young physician was born on Aug. 19, 1908, in New York City. He received the Bachelor of Arts degree in 1929 from Fordham University, New York City, and the Doctor of Medicine degree in 1943 from the Georgetown University School of Medicine, Washington, D. C. His first residency was at the Gallinger Hospital in Washington.

A specialist in internal medicine, Dr. Flynn had practiced in St. Petersburg for five years. He was a member of the staffs of Mound Park and St. Anthony's Hospitals. He was a member of the Pinellas County Medical Society, the Florida Medical and the American Medical Association.

Surviving him are his wife, Mrs. Dorothy Flynn; two sons, Edward L. and Charles, all of St. Petersburg; a brother, John L. Flynn, and a sister, Mrs. George Howley, both of New York City.

WOMAN'S AUXILIARY

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MRS. JOHN F. LOVEJOY, State Bulletin Editor.....*Jacksonville*
MRS. RICHARD F. STOVER, Romance of Medicine.....*Miami*

Results of Letters to Congressmen On Compulsory Health Insurance

Dear Auxiliary Members:

For many months now, you have been working long and hard in close cooperation with the county medical societies, obtaining resolutions, letters and cards to send to our Senators and Representatives, enlisting their fight against compulsory health insurance. Like me, I am sure you wondered many times how soon this avalanche of resolutions and correspondence would bring about any appreciable results.

That day arrived when on August 16 sixty of our Senators (not the two from Florida, however) voted for disapproval of President Truman's Reorganization Plan No. 1. As I see it, this means that the majority of our Senators consider health activities of such importance that they should be conducted under a single department rather than in conjunction with other activities. They feared, too, that this plan, if allowed to go into effect, might be a step toward the adoption of socialized medicine.

In grateful appreciation to these sixty Senators, I wrote each a personal letter expressing sincere thanks from all of you. Thinking that they were much too busy to acknowledge a letter of praise, I was amazed to receive in one week cordial notes from twenty-three of them, many expressing personal dynamic views. To quote a few:

"Many thanks for your kind letter of August 23, commending me for my stand on Reorganization Plan No. 1. I am glad to assure you that I

(Continued on page 244)



From where I sit
by Joe Marsh

Watch Out For The Symptoms!

Laughed right out loud when I heard Hoot Davis had come down with Chicken Pox. A man of forty-five catching a kid's disease!

I went to see him, armed with jokes about "second childhood" but forgot them fast when I got there. Hoot looked awful and had quite a fever.

While we talked, I thought of how Chicken Pox is a lot like other "diseases"—diseases of the character, such as intolerance, self-righteousness or just plain ignorance. They're excusable in children, but when they come out in adults they're ten times as bad—and can be mighty "contagious."

From where I sit, we should all watch out for the "symptoms"—little things like criticising a person's preference for a friendly glass of temperate beer or ale. We've seen freedom wither away in other countries, when individual intolerance was allowed to get out of hand and become a nationwide epidemic.

Joe Marsh



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will continue my efforts to defeat any proposed legislation such as this Plan which I sincerely believe was designed to open the door to socialized medicine in this country."

"It was nice of you to write in regard to my vote against President Truman's Reorganization Plan No. 1. This appears to be just the first skirmish in the long, hard fight to resist the efforts of the Leftists to regiment our Medical Profession. As a result of my vote, the Farmers' Union members in my own state, who are very close to the CIO, have been making it pretty tough for me. However, I expected this."

"Thanks for your generous and thoughtful letter of August 23. An occasional message of this nature is a source of real stimulation and encouragement."

"I assure you that I shall continue to vote against any bill which proposes socialized medicine."

"Being a very human person, I can always take a moment out of days busier than I have ever known, to express my appreciation for your kind words."

"It is gratifying to know that one's action in the Senate meets with such approval."

"I am glad to have this expression of your views and to know that your organization supports the position of the 60 Senators who voted to disapprove the President's Plan as not conforming to the Hoover Commission recommendations for separation of health and welfare functions of our government."

"I shall certainly continue to do all I can here at Washington to preserve the fundamental principles of our democracy."

Let us be as generous with our letters of praise as we are with our letters filled with requests. If you have been resting and cooling in the shade (and who could blame you?) these last two months, let me urge you to be up and hustling with personal contacts and letters to Congressmen, and certainly to be on the alert for any new Reorganization Plan that may pop up.

Yours for continued service,
Mrs. Charles F. Henley



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GYNECOLOGY—Intensive Course, Two Weeks, starting October 24.

Vaginal Approach to Pelvic Surgery, One Week, starting November 7.

OBSTETRICS—Intensive Course, Two Weeks, starting November 7.

MEDICINE Intensive General Course, Two Weeks, starting October 3.

Gastroenterology, Two Weeks, starting October 24.

Gastroscopy, Two Weeks, starting October 24.

DERMATOLOGY—Formal Course, Two Weeks, starting October 24. Informal Clinical Course every two weeks.

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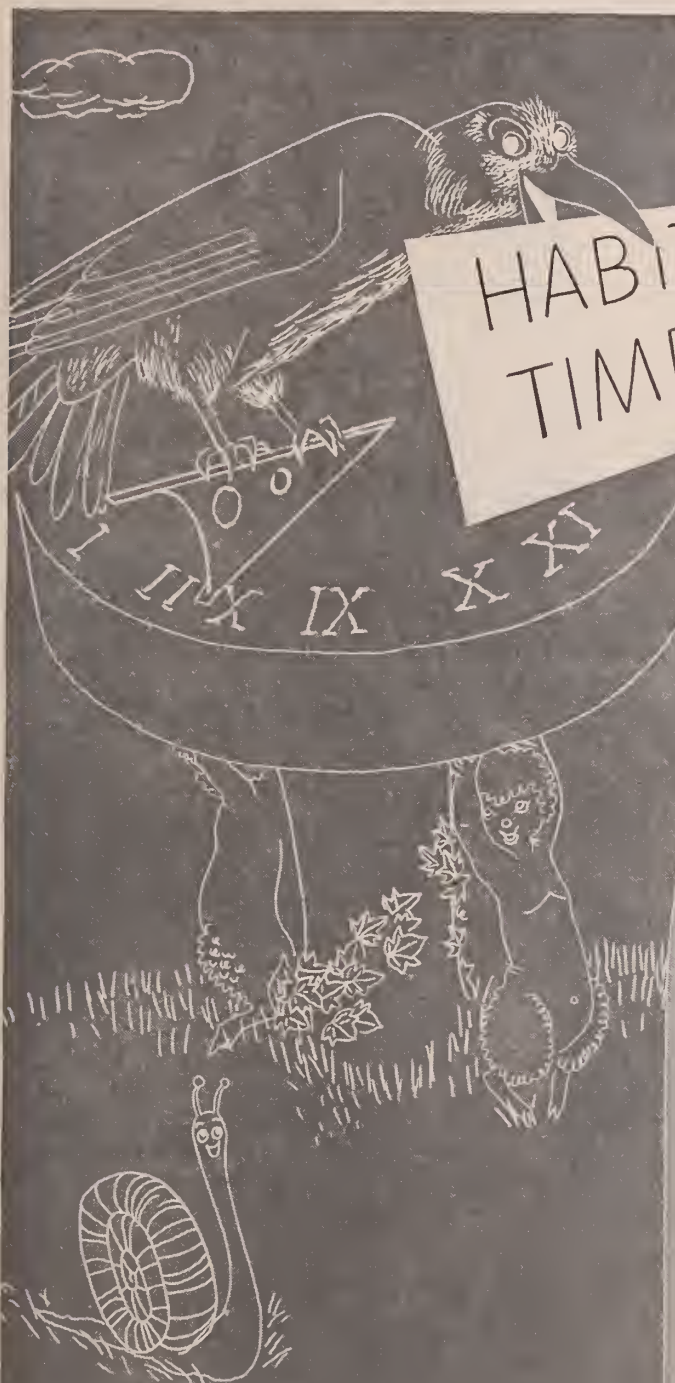
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<i>obstetrics</i>	<i>anemia (with iron)</i>
<i>varicose veins</i>	<i>hydrocele</i>
<i>trachoma</i>	

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<i>auricular fibrillation</i>	<i>ventricular tachycardia</i>
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Quincy, Oct. 24, 1949
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Palatka, Oct. 26, 1949
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Sebring, Oct. 27, 1949
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	Ft. Lauderdale, Oct. 28, 1949
Florida Specialty Societies			
Allergic Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthalm. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society		Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Edgar W. Stephens, Jr., W. P. Beach	Hugh A. Carithers, Jacksonville	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewitt, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	November, 1949
Hospital Service Corporation	Mr. W. F. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, Nov. 27-29, '49
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	Sarasota, October, '49
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach
Public Health Association	Turner E. Cato, Miami	Mr. Fred B. Ragland, Jacksonville	West Palm Beach, Oct. 6-8, '49
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, April, 1950
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
Southern Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loran, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
S. E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	April 5-7, 1950
Southeastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., 1950
Southeastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5, '50
Southeastern Surgical Congress	R. J. Wilkinson	B. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
Gulf Coast Clinical Society	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	Pensacola, Oct. 6-7, '49

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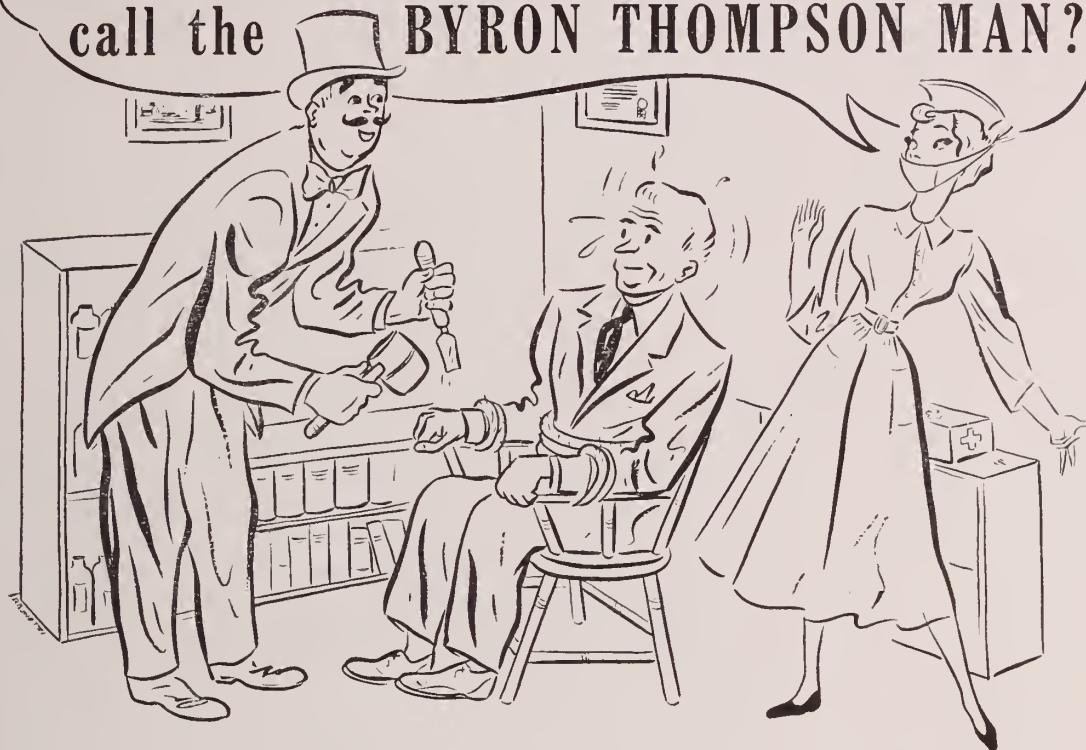
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Martle F. Parker, M.D. Panama City	Russell T. Stewart, M.D. 224 East 4th St. Panama City		15	100%	
Escambia *Santa Rosa	Alvyn W. White, M.D. 24 W. Chase St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	64	60	
Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Wewahitchka	3rd Tuesday Old Months	7	6	A-1-50 William P. Hixon, M.D. Pensacola
Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	17	
Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
Washington-Hohnes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	46	44	A-2-51 Taylor W. Griffin, M.D. Quincy
Suwannee	Joshua M. Price, M.D. Live Oak	Ibby H. Black, M.D. 918 W. Howard St. Live Oak		6	100%	
Madison	A. Franklin Harrison, M.D. Madison	Merwin E. Buchwald, M.D. Box 214 Madison		4	100%	
Taylor *Dixie-LaFayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	1st Friday 8:00 P.M.	4	3	199
Alachua *Bradford, Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	38	100%	
Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	Janet G. Leser, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	252	237	
Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	30	28	B-3-50 Charles C. Grace, M.D. St. Augustine
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	1st Friday 8:00 P.M.	9	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	
Brevard	Charles E. Russell, M.D. Box 9 Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	15	100%	
Lake *Sumter	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	20	100%	
Orange *Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	135	131	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
Seminole	Leonard I. Munson, M.D. Touchton Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	55	54	590
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

NOVEMBER, 1949

OF MEDICINE

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IN THIS ISSUE

Master Two Step Exercise Test Coronary Insufficiency

Karl B. Hanson, M.D.



Commoner Hemorrhagic Diseases

James N. Patterson, M.D.



Rheumatic Disease

Kenneth Phillips, M.D.




American Druggist Surveys British State Medicine

An Editorial



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¹Krantz, J. C., Jr., and Carr, C. J.:

Pharmacologic Principles of Medical Practice,
Williams & Wilkins Co.,
Baltimore, 1949, pps. 114-119.

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CONTENTS

SCIENTIFIC ARTICLES

The Master Two Step Exercise Test in the Diagnosis of Coronary Insufficiency, Karl B. Hanson, M.D.	275
Diagnosis of the Commoner Hemorrhagic Diseases, James N. Patterson, M.D.	280
General Allergies in Children, Charlotte C. Maguire, M.D.	287
Clinical Response to Crowe's Vaccine in One Hundred and Twenty-Five Cases of Rheumatic Disease, Kenneth Phillips, M.D.	290

ABSTRACTS OF MEDICAL ARTICLES

The Use of Radon Ointment in the Treatment of Late Irradiation Ulcers, David Kirsh, M.D., J. Francis Mahoney, M.D., and Eugene P. Pendergrass, M.D.	294
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(Continued on page 279)

EDITORIALS

The American Druggist Surveys British State Medicine	298
Whither Would You Flee?	298
The Nation's Daily Disaster	299

COMMENTARIES

A. M. A. Clinical Session	300
Annual Grass Roots Conference	300
Duval County Medical Society New Auditorium Opened	300
Refraction Offer Investigated	301
What Is the A. M. A.?	302
Report of Delegates to A. M. A. Convention	302
Florida Legislature	306

GENERAL FEATURES

Officers and Committees	296, 297
Your Blue Shield	308
National Education Campaign	309
Deaths	309
State News Items	309
Medical Officers Returned	310
Medical Licenses Granted	311
New Members	312
Component Society Notes	312
Obituaries	312
Woman's Auxiliary	317
Schedule of Meetings	329
List of County Medical Societies, Presidents and Secretaries	330

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Bibliography: 1. Ware, H. H., Jr.:
Virginia M. Monthly 70:238, 1943.

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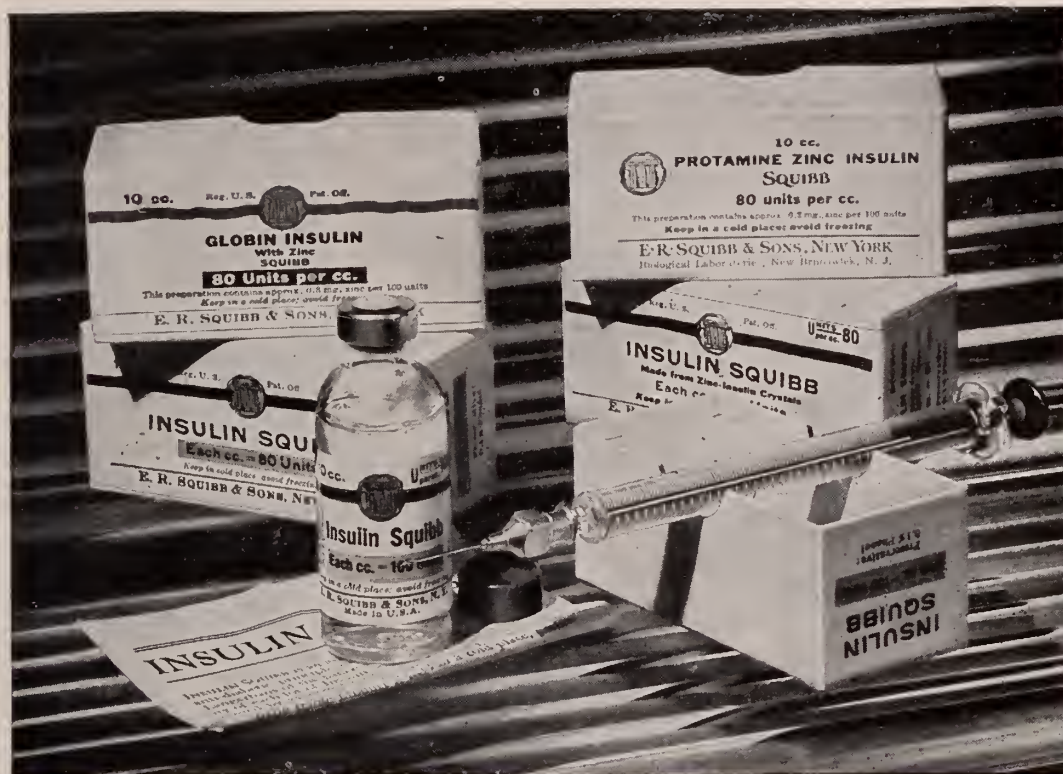
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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.



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1. Best, R. R.: Ann. Surg. 128: 348 (Sept.) 1948.

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1. Rawls, W. B.: New York Med. (no. 15) 3:19, 1947.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (Apr. 2,) 1949

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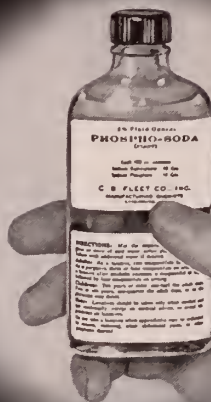
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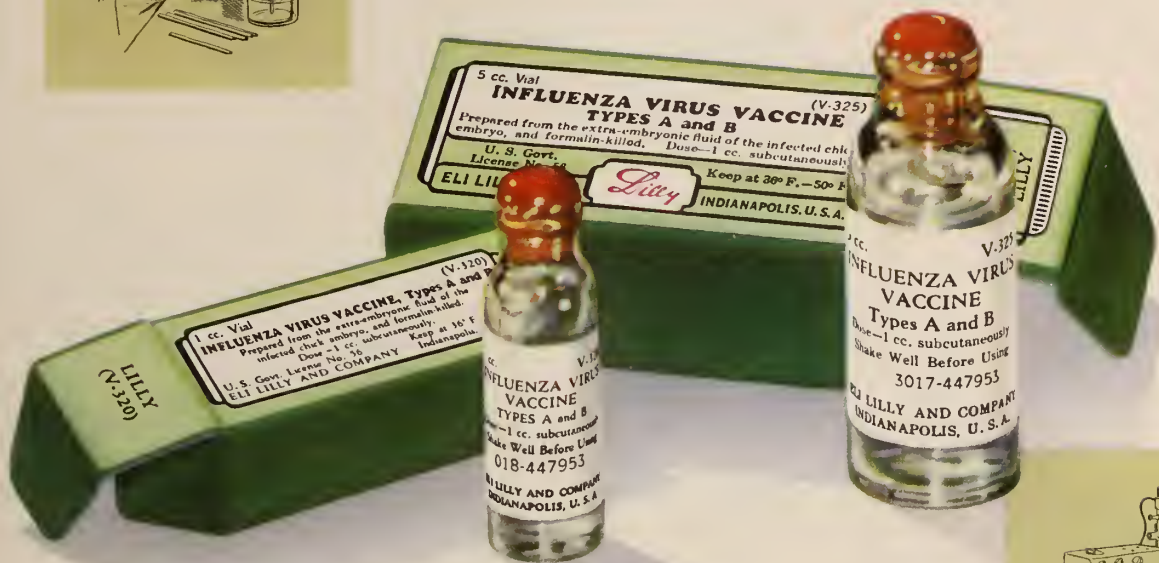
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LILLY SPECIALISTS SERVE THE MEDICAL PROFESSION

The Master Two Step Exercise Test in the Diagnosis of Coronary Insufficiency

KARL B. HANSON, M.D.

JACKSONVILLE

In about 17^{1a} to 25 per cent² of patients having angina pectoris electrocardiograms give negative evidence. Master^{1a} in 1948 stated that about 20 per cent of pains in the chest aside from traumatic injury are due to disease of the coronary arteries. Not infrequently, one experiences some doubt as to the significance of pain in the chest despite careful questioning of the patient. At times, a patient may give a typical history of angina pectoris; but he may be drawing compensation or disability insurance, and because of this fact some doubt may arise as to the diagnosis. Most investigators^{3,4} agree that the history of the patient is the most valuable diagnostic criterion of angina pectoris. In doubtful cases, it is desirable to have good objective evidence of the ischemia of the myocardium. It is seldom possible to get an electrocardiogram during a spontaneous attack of angina.

Feil and Siegel⁵ in 1928 were the first to make electrocardiographic observations during angina pectoris purposefully induced by exercise. Since then numerous observers have shown the various changes that may occur. Various methods of obtaining electrocardiographic studies of myocardial ischemia secondary to exercise have been described.

Riseman, Waller and Brown⁶ in 1940, after making an exhaustive study and using a test not varied according to age, weight or sex, concluded that exercise tests and anoxemia tests are not reliable. Feil and Pritchard⁷ used a test whereby the patient goes across a standard two step Master stairs until dyspnea or pain results. They set up the range for the normal and criteria for establishing the presence of coronary disease. Levy³ used the anoxemia test designed by himself and his co-workers, and set up standards for the diagnosis of coronary insufficiency. He used 10 per

cent oxygen. He rarely had unfortunate accidents with his test.⁸ Levine⁴ used a simple exercise such as walking up and down stairs to ascertain whether pain was produced. Master,^{1b} using the 10 per cent oxygen test to confirm his own results, had to stop the test in 1 case because the patient became too exhausted to finish.

The Master two step exercise test has been standardized on normals for age, sex and weight. It has been stated that the work performed involves about 1/8 horsepower for men and 1/11 for women.^{1a} Master stated that as far as the electrocardiogram is concerned, athletic training will not influence the result of the test. The technic^{1c} involves climbing a two step stairs, each step 9 inches high, a given number of times in a definite length of time. These figures can be found in the literature.^{1b,c} The patient must have a control tracing run first, but not within one hour of a meal.^{1a} The test is not done if the findings of coronary insufficiency on the control electrocardiogram are definite. This test avoids severe exercise which might produce electrocardiographic changes in a normal person. The two step test produces no alarm as climbing stairs is an ordinary everyday type of activity. There are two tests. The first is the calculated number of trips in ninety seconds. If the first test gives negative results, the second test should be made. In this, the number of trips and the length of time are doubled; in other words, twice the number of trips in one hundred and eighty seconds. The electrodes and wires must be attached to the patient while performing the exercise so that four leads of the electrocardiogram can be run within one minute, two minutes and six minutes after completing the exercise.^{1a} The second test should be made after a period of twenty-four hours or more following the first test.

The criteria for the diagnosis of coronary in-

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 12, 1949.

sufficiency as quoted by Master¹ are any one or more of the following:

1. RS-T segment depression as compared to the PR interval of more than 0.5 mm. in any lead. He stated that ST segment depression never occurs normally.

2. Flattening or inversion of an upright T wave, particularly in leads I, II and IV, or an inverted T wave becoming upright, or a flat T wave becoming upright or inverted.

3. Widening of the QRS complex or PR interval.

4. The occurrence of premature beats not seen in the control tracing or some other significant arrhythmia.

5. The appearance of large Q waves or heart block.

Master^{1b} stated the changes are due to anoxemia, as can readily be demonstrated by reproducing identical changes with the 10 per cent oxygen anoxemia test.

Results

Practically all of the tests were run on patients with some discomfort in the chest suggestive of coronary heart disease (table 1). No ef-

Table 1

Results of Tests on 65 Patients*

Age	Positive	Negative	Total
20-30	0	2	2
31-40	5	4	9
41-50	5	20	25
51-60	5	13	18
61-70	5	8	13
71 plus	0	1	1

*Only 1 had no complaint of chest distress of some type.

Results of Tests on 46 Male and 19

Female Patients

	Male	Female	Total
Positive	16	9	25
Negative	32	8	40
Questionable	4	2	6

Double tests were run on 6 patients. Results: 2 positive, 4 negative.

fort was made to run the test on persons supposedly normal. It is interesting to note that of 65 patients with pain in the chest, in some instances typical, in some atypical, and in some due mostly to the patient's own anxiety, 37.8 per cent

gave a positive reaction to the test and about 10 per cent a questionable result. The age distribution was what might be expected from the known incidence of coronary heart disease. The sex distribution was also in about the same proportion as the natural occurrence of coronary disease in the two sexes. The proportion of positive reactions was higher among the women than among the men; however, there were so few women tested that accurate comparison cannot be made.

Master^{1a} stated that 17 per cent of patients with angina pectoris have a negative resting electrocardiogram. In this series, the majority of the exercise tests were on patients giving a suggestive history but having a negative or questionable resting electrocardiogram (table 2). Of the 21 pa-

Table 2

Number of Control Electrocardiograms

Final Diagnosis	Number	Positive Test	Negative Test
Patients with angina	21	5 (23.8%)	16 (76.2%)
Coronary insufficiency	11	5 questionable (45.4%)	6 (54.6%)
No coronary heart disease found	34	1 questionable (2.9%)	33 (97.1%)

Exercise Test Electrocardiograms

Final Diagnosis	Number	Positive Test	Negative Test
Angina	21	15 (71.4%)	6 (28.6%)
Coronary insufficiency	11	11 (100%)	0
No coronary heart disease found	34	(2.9%) 1 questionable	33 (97.1%)
Anxiety states included in above figures	9	4 (44%)	5 (56%)

tients having a final diagnosis of angina pectoris only 5 or 24 per cent had abnormal control tracings, and all of these did not show positive changes suggesting coronary insufficiency after exercise. After the test, 71.4 per cent were positive. Of the 66 tested, 13 had (table 3) hypertension and in 6 of these there was a positive reaction to the test. In 8 of the entire group tested the heart was enlarged to some degree. Of the 68 control tracings, only 6 were abnormal and 6 questionable. None of these showed ST segment deviations. Seven of these 12 showed no other evidence of heart disease. More than two thirds of all patients tested, therefore, had no objective evidence of cardiovascular disease. In 1 patient severe angina developed during the test, but it subsided after a few minutes. No other untoward results were experienced. See figures 1, 2, 3 and 4.

Table 3

Diagnosis	Number	Control		Test		Elevated Blood Pressure	Enlarged Heart
		Positive	Negative	Positive	Negative		
Angina	21	5	16	15	5 1 questionable	7	4
Coronary insufficiency	11	5 questionable	6	11		2	1
No coronary heart disease	34	1 questionable	33	1 questionabl	33	4	3
Anxiety states	5		5		5		
Anxiety states with coronary insufficiency	4	1	3	4			

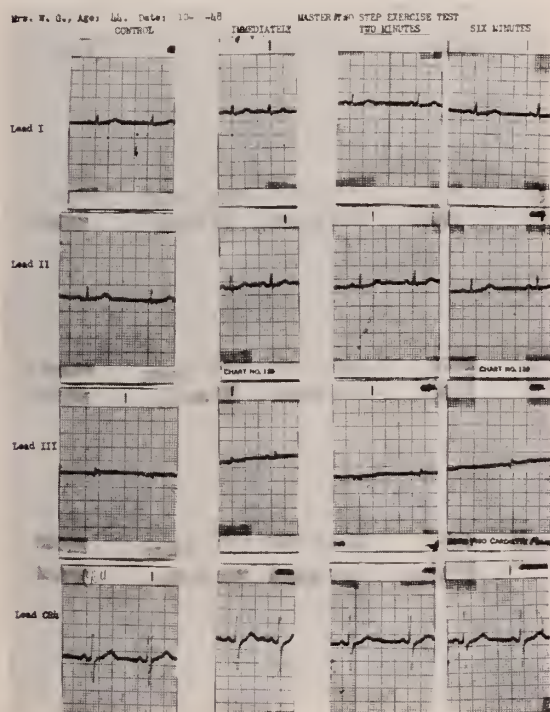


Fig. 1.—Mrs. W. G., aged 44, a school teacher, had one episode of heaviness under the sternum lasting ten minutes, which was associated with a feeling of pressure and pain. She then had shooting pains over the precordium. The onset occurred three weeks before these tracings were run. Result of test: normal.

Discussion

Riseman, Waller and Brown⁶ stated in 1940 that after exertion the electrocardiogram appeared to be of little practical value in the diagnosis of angina pectoris or disease of the coronary arteries. Yet they concluded in the same study that electrocardiographic changes induced by exertion could be delayed by having patients breathe oxygen before and during the exercise. The reason for this attitude is possibly attributable to not having a standardized test routine.

Some consideration must be given to the influences outside of the heart that might alter the electrocardiogram. Grossman, Weinstein and Katz⁸ believed that influences other than anoxemia may

lead to depression of the ST segment and flattening or inversion of the T wave. They listed change of position, increased activity of the sympathetic nervous system as in neurocirculatory asthenia and anxiety, sympathomimetic drugs, tachycardia and hyperventilation. These authors concluded, however, that although the test is empiric, it is of value in the differential diagnosis of coronary insufficiency. They stated that the positive response is of value and that in their series of cases they did not have one false positive result. Master^{1a} stated that when definite alterations occur as a result of the test, the coronary circulation is not normal. He avoided testing a patient within one hour after a meal, or when convalescing from a severe illness. He also avoided exposure to low temperatures during the test. He cautioned that neurocirculatory asthenia and

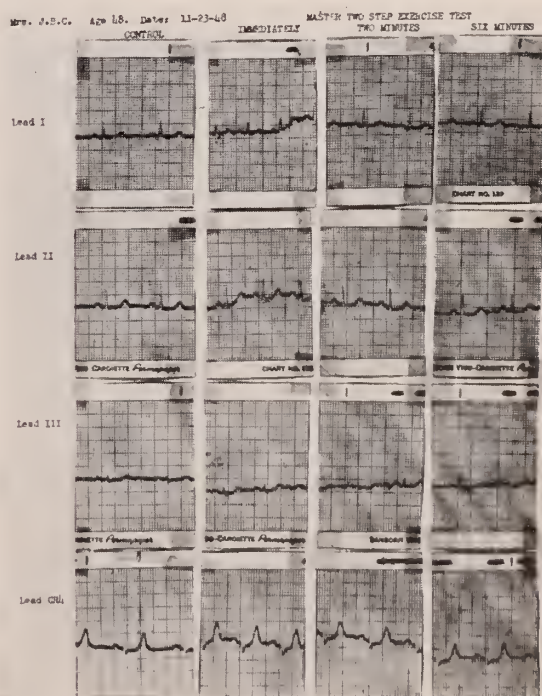


Fig. 2.—Mrs. J. B. C., aged 48, was referred for an electrocardiogram only. Result of test: coronary insufficiency.

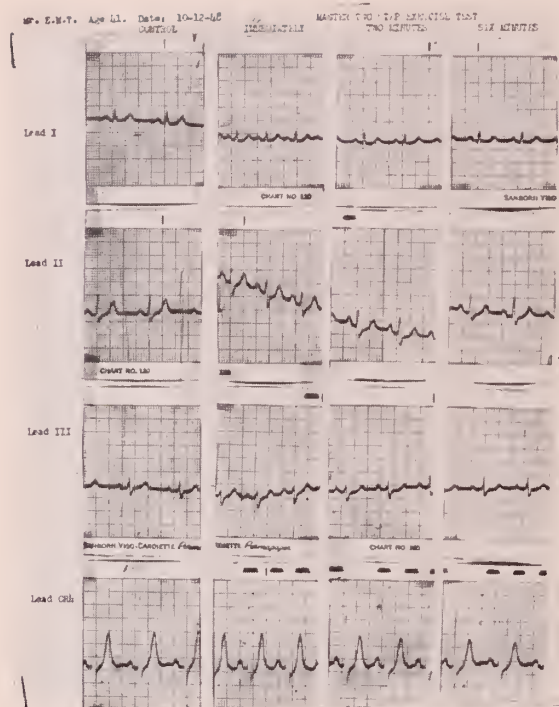


Fig. 3.—Mr. E. M. T., aged 41, worked in a print shop. Three weeks before, he had experienced sudden vicelike pain under the sternum, which was relieved by rest. After these tracings were run, he was put to bed with bathroom privileges. Twenty-four hours later he was hospitalized with coronary thrombosis. Result of test: coronary insufficiency.

tachycardia may be confusing, but that both conditions should be obvious. It seems probable that all the positive reactions to the Master tests were the result of myocardial anoxemia as in the same patients he was able to duplicate the abnormal changes with the anoxemia test.

Master^{1a} and also Grossman, Weinstein and Katz² emphasized that the test is only of value when the results are positive. Recently, however, Master^{1a} stated that in his experience if both tests give negative results, the patient probably will not experience serious coronary disease within a year. In the series of cases reported here there were a few patients with clinical angina whose response to the test was negative. There probably would have been fewer negative results had there routinely been carried out the double test on all patients with negative first reactions.

Master^{1c} and Grossman, Weinstein and Katz² stated that the positive changes may occur within one minute of the exercise or several minutes later. This has been our experience. The test has been a valuable diagnostic aid in the differentiation of cardiac disease manifested by pain in the chest.



Fig. 4.—Mrs. M. D. McK., aged 63, a housewife, had experienced pains for twenty years. Pain in the left arm going up under the breast bone made her stop. The pain would go away, but would recur if she worked hard. Attacks did not occur daily until six years prior to this examination. Now they were occurring several times daily, and following heavy meals. The patient was never before convinced that she had heart disease. Result of test: coronary insufficiency, severe.

Summary

A standardized exercise test, with employment of the Master two step technic, was used on 65 patients, all but one having some type of chest complaint suggestive of heart disease. In 25 or 37 per cent there was a positive result. Only 6 had changes in the control electrocardiograms compatible with coronary disease before the test.

The Master test is a safe test for coronary insufficiency.

This type of exercise test makes it possible to obtain objective evidence of coronary insufficiency in a much higher percentage of patients with disease of the coronary arteries or other heart disease.

The test is mostly of value when the response is positive. When a double test gives negative results, it might be inferred that at the moment relatively good coronary reserve exists.

The test is a valuable aid in the differentiation of cardiac disease associated with pain in the chest.

The criteria set up by Master¹ were used in this study.

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Discussion

DR. JERE W. ANNIS, Lakeland: From my experience with this test, I can only re-emphasize several points in Dr. Hanson's paper. First, I should like to confirm his remarks in two respects: (1) The Master's test is far from being the ideal test. (2) It is the best practical test we now have available. There is no question but that we need much better methods of study for coronary insufficiency. The Levy test gives a greater percentage of positive results, but, in my opinion, definitely increases the hazard to the patient.

It is important to remember that all these functional tests of cardiac capacity and reserve depend upon the production of a definite if temporary current of injury in the heart muscle. The disadvantage of the Master's test is that negative results cannot be relied upon. This is of particular importance in cases of cardiac neurosis and in compensation cases in which we particularly need a test giving definitely negative objective results. The advantages are many: (1) It can be done in the doctor's

office without additional equipment or personnel. (2) It is a standard test, and its results can be compared with various other tests or with the same test in other hands. (3) It entails a minimum of emotional factors. There is no sensation of smothering, and the patient has the feeling that he can terminate the test at any time. (4) It is relatively safe. I do not think that it is as safe as Master himself believes it is. (5) It enables us to make the diagnosis of coronary insufficiency in an appreciable group of patients without other objective indications of coronary disease. This advantage is of tremendous importance. Many times, this test furnishes the physician with the much needed reassurance to corroborate his clinical impression of coronary insufficiency.

In short, the Master's test, it seems to me, is not a perfect test, perhaps it is not even a really good test; but, it is the best practical means of evaluation which we have for the study of these cases.

DR. S. MARION SALLEY, Miami: I enjoyed Dr. Hanson's paper. The Master two step exercise test needs to be in wider use because, while it is by no means perfect, it is practical. It is of greatest value when one is dealing with patients who, because of insurance for example, wish to be considered victims of coronary insufficiency. As Dr. Hanson implied, this is its most important use. In the ordinary case the patient does not wish to have angina pectoris, and the history is usually dependable and sufficient to make the diagnosis.

This test first came to my attention during the war while I was stationed at Walter Reed General Hospital. Dr. George Robb, in charge of the cardiac section, began using it on all general officers and colonels of the regular Army before they were allowed to go overseas. In the first World War, among the general officers and colonels in the regular Army, there were between 18 per cent and 20 per cent physical breakdowns. In this war, due at least in great part to the use of the Master exercise test to weed out the unfit, the physical breakdowns amounted to less than 4 per cent.

One day while making rounds, I asked one colonel what he had been doing when he incurred myocardial infarction. He replied that it had developed while he was taking the Master exercise test at Walter Reed Hospital. He hastened to add that he had every confidence in the cardiac service there despite this occurrence and realized he would undoubtedly have incurred it anyway under some other conditions. I believe that his attitude might have been different had the anoxemia test with a mask over his face been the occasion of the infarction.

Dr. Hanson's presentation of the test is indeed timely.

ABSTRACTS OF MEDICAL ARTICLES

(Continued from page 260)

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|---|-----|
| Roentgen Manifestations in the Skull of Metastatic Carotid Body Tumor (Paraganglioma), of Meningioma and of Mucocele, a Report of Three Unusual Cases, Eugene P. Pendergrass, M.D., and David Kirsh, M.D..... | 294 |
| The Role of Irradiation in the Management of Carcinoma of the Breast, Eugene P. Pendergrass, M.D., and David Kirsh, M.D..... | 295 |
| Study of Ureteral Blood Supply and its Bearing on Necrosis of the Ureter Following the Wertheim Operation, John P. Michaels, M.D..... | 295 |
| Study of the Disappearance of Congo Red from the Blood of Non-Amyloid Subjects and Patients with Amyloidosis, Paul N. Unger, M.D., Morris Zukerbrod, M.D., Gustav J. Beck, M.D., and J. Murray Steele, M.D..... | 295 |
| The Prothrombin Response to the Parenteral Administration of Large Doses of Vitamin K in Subjects with Normal Liver Function and in Cases of Liver Disease: A Standardized Test for the Estimation of Hepatic Function, Paul N. Unger, M.D., and Shepard Shapiro, M.D. | 296 |
| Hyperprothrombinemia Induced by Vitamin K in Human Subjects with Normal Liver Function, Paul N. Unger, M.D., and Shepard Shapiro, M.D. | 296 |

When a physician is confronted with a patient afflicted with one of the hemorrhagic diseases, how can he proceed to classify properly this disease? As stated previously, an accurate diagnosis is necessary before treatment can be intelligently instituted to correct the deficiency. This can usually be made by a correlation of the history and physical findings with the results of the laboratory examinations. The history must be taken carefully with emphasis on the incidence of bleeding in other members of the family, the age at which bleeding began, and the site and severity of the bleeding. A thorough physical examination will often uncover important signs leading to the diagnosis. For example, a telltale lesion in the skin of a patient with hereditary hemorrhagic telangiectasia may focus attention on a similar lesion elsewhere which is responsible for the loss of blood and hypochromic anemia so frequently present in patients with this disease.

What laboratory procedures should be carried out in arriving at a proper diagnosis as to the cause of bleeding? These are listed below together with the particular method recommended for each test.

1. Complete blood count—hemoglobin, red blood cell count, white blood cell count and differential.

2. Bleeding time—Duke method (or Ivy).

3. Coagulation time—Lee and White.

4. Clot retraction—Lee and White.

5. Platelet count—Rees and Ecker (also estimated on differential).

6. Rumpel-Leede test.

7. Prothrombin determination—Quick's method (Link-Shapiro modification).

8. Fibrinogen (occasionally)—micro-Kjeldahl method.

9. Calcium (rarely, if ever)—Kramer-Tisdall method (Clarke-Collip modification).

10. Recalcified plasma test (Howell's prothrombin time)—in suspected hemophilia.

It is important in most instances to perform at least the first seven tests outlined before administering blood, blood plasma or vitamin K. If the time required to complete these tests may jeopardize the patient's life, and blood or blood plasma must be given, an estimation of the bleeding time and capillary fragility should be made, if possible, and enough blood drawn to complete the other laboratory procedures before starting treatment. Vitamin K should rarely, if ever, be

given before blood is drawn to do the laboratory work, for to do so may prevent proper diagnosis in cases of prothrombin deficiency. In extreme emergencies, however, blood must be given without delay. In most of these cases, the diagnosis usually can be made later, for transfusions, as a rule, only produce temporary changes in the different constituents.

The different hemorrhagic states coming under each of the three large groups previously mentioned are now considered, and for brevity's sake there are listed only the positive laboratory findings of value together with pertinent history and clinical manifestations, which will enable one to make the correct diagnosis. The degree of anemia in all cases, unless otherwise mentioned, is directly proportional to the amount of blood lost.

I. Due primarily to changes in coagulation

A. Deficiency of prothrombin

1. Due to dietary defects of vitamin K
 - a. Hemorrhagic disease of the newborn
 - b. Dietary defects in adults
2. Due to faulty absorption of vitamin K
 - a. Jaundice—lack of bile salts
 - b. Chronic diarrhea from any cause
 - c. Ulcerative colitis
3. Impaired formation by the liver
 - a. Diffuse hepatitis
 - b. Cirrhosis of the liver
 - c. Liver poisons
4. Administration of dicumarol
5. Idiopathic hypoprothrombinemia

Laboratory findings:

Prothrombin time—prolonged
Coagulation time—prolonged
Bleeding time—usually prolonged

The same laboratory findings are present whether the deficiency of prothrombin is due to dietary defects or faulty absorption of vitamin K, impaired formation by the liver, the administration of dicumarol which prevents the synthesis of prothrombin or idiopathic hypoprothrombinemia. Because the prothrombin is decreased in amount, the prothrombin time is prolonged, the coagulation time is lengthened, and the bleeding time is usually increased because the formation of the clot is delayed. The clot retraction, the tourniquet test and the platelets are, however, almost invariably normal. It should be stressed that the coagulation time will not be increased in any prothrombin deficiency until the prothrombin level drops to at least approximately 20 per cent of the normal, which is about the equivalent of the prothrombin content present when the patient's prothrombin time in seconds is 2.5 times the normal control for undiluted plasma and 3.5 times the control for 12.5 per cent plasma.

Hemorrhagic disease of the newborn due to

hypoprothrombinemia occurs within two days to a week's time in about 0.5 per cent of all newborns. It can be prevented by the administration of vitamin K to the mother before delivery or immediately at birth to the child. This condition in the infant can be treated by intramuscular or intravenous injection of 2 mg. of vitamin K.

All physicians have seen jaundiced patients with prolonged coagulation and bleeding times associated with hemorrhage. Before the discovery that this condition was due to a prothrombin deficiency, these patients were treated with calcium salts and transfusions. No patient with jaundice should be subjected to an operation without first having had a prothrombin time determination, or, if facilities are not available, the patient should be given sufficient vitamin K to insure an adequate plasma prothrombin content. The prothrombin time, in addition, is of considerable value in estimating liver function. Many of these patients have a normal coagulation time before operation because the prothrombin content is above the level of approximately 20 per cent, but as a result of the anesthetic and loss of blood it may quickly drop below the critical level, and bleeding will occur. In any condition in which the food passes quickly through the intestinal tract, as in diarrhea or in a short-circuiting operation, a prothrombin deficiency may occur.

Prothrombin deficiency can be corrected by vitamin K therapy administered orally if there is adequate absorption and a good-functioning liver, and parenterally if the latter criterion is met. Transfusion of fresh whole blood in adequate amounts will immediately elevate the prothrombin content to above the critical level. If only prothrombin Fraction B, which is stable in stored blood or plasma, is concerned in coagulation, as suggested by Quick,¹ then stored whole blood or plasma should be equally effective.

- I. Due primarily to changes in coagulation (continued)
 - B. Deficiency of thromboplastin

1. Hemophilia

Characteristic laboratory findings:

Coagulation time—prolonged. In general the more it is prolonged the more severe the hemophilia.

Bleeding time—normal

Recalcified plasma time (Howell's prothrombin time)—prolonged. Hemophilic plasma subjected to high centrifugation clots significantly slower than the same plasma centrifuged at low speed, for in the latter the platelets will not all be removed from the plasma and will break down releasing thromboplastin.

Hemophilia is of course limited to the male. This disease is transmitted as a mendelian recessive, sex-linked character from the male to an unaffected but carrier-female to a grandson. Diagnosis of this condition is based upon a history of repeated episodes of excessive bleeding in the male beginning early in life and the demonstration that the coagulation time is prolonged, often to a pronounced degree. The family history indicating that the disease is hereditary and sex-linked is confirmatory evidence. It is sometimes impossible to obtain a complete history in these patients, and then, too, sporadic cases have occurred probably by mutation of sex cells of the mother, which marks the beginning of a new strain of hemophilia.

In hemophilia, hemorrhage occurs usually within the first two years of life. Birch⁵ stated that in 25 per cent of the cases the initial hemorrhage occurs within the first three weeks of life. Bleeding in hemophilia occurs in the subcutaneous tissues, muscles and joints, with slight or no demonstrable trauma. Because of hemorrhage into joints, there is frequent deformity and ankylosis of the affected joint, most commonly the knee. Bleeding may occur from the mouth, the gums or the nose, and in approximately one third of the patients there is hemorrhage into the stomach or enteric tract. It may also occur from the bladder or kidneys, but the central nervous system is rarely involved. Petechiae are rare.

The prothrombin time is normal in this condition because there is no deficiency of prothrombin, but the coagulation time is delayed. This delay, as indicated, is probably due to a decrease in the amount of thromboplastin which is necessary to neutralize the heparin before the clotting mechanism can be set in motion. Thromboplastin is derived chiefly from the platelets, but apparently there is also some thromboplastin free in the plasma for the giving of plasma, or even prothrombin-free, fibrinogen-free plasma, will restore the clotting time to normal. The platelets are not decreased in number. In other words, the defect is not a quantitative but a qualitative one in which the platelets are more resistant so that they break down with difficulty, thus slowly releasing the thromboplastin. The bleeding time as determined by either the Duke method or the Ivy method is normal. This is explained by the fact that in performing a bleeding time determination the tissue cells are injured by the lancet, liberating thromboplastin in quantity large enough

to produce quickly a clot, and because the platelets are present in normal numbers to fill in the interstices of the clot. Since the platelets are quantitatively normal, they produce retraction of the clot. Since there is usually no damage to the capillary wall, the tourniquet test gives negative results.

Treatment of this condition is transfusion with whole blood, plasma or plasma protein Fraction I. One hundred and fifty cubic centimeters of blood tends to control the bleeding for twenty-four hours. About 120 to 150 cc. of liquid plasma or reconstructed dried plasma will produce the same effect, as will 200 to 600 mg. of plasma Fraction I in 5 to 10 cc. of physiologic saline injected intravenously. It is most important that in a hemophiliac no operation be performed until the coagulation time is brought down to at least twenty minutes or lower by the Lee and White method. This reduction can be made by any one of the three methods mentioned.

At this time it is well to discuss briefly a not too uncommon hemorrhagic disease called pseudohemophilia (hereditary pseudohemophilia, hereditary hemorrhagic thrombasthenia and familial purpura). The mechanism of this disease is still a mystery, and consequently it does not fit well into any classification of hemorrhagic diseases, especially one based upon a deficiency. According to Sturgis,^{11a} this is a chronic familial hemorrhagic disease which occurs in both sexes and may be transmitted by either parent. It is characterized chiefly by a prolonged bleeding time with a normal platelet count, coagulation time and clot retractility. It is transmitted as a mendelian dominant. The disease manifests itself by abnormal bleeding from the gums and nose and into the skin and subcutaneous tissue following slight trauma. Loss of blood may, however, occur from any part of the body resulting in a microcytic hypochromic anemia.

Clinically the disease may resemble hemophilia, but by laboratory studies it is easily distinguishable. Then, too, it is also found in the female and may be transmitted by either parent.

Treatment of pseudohemophilia consists of blood transfusions. The prognosis is ordinarily good as the condition tends to have its onset in children and to become less active as the child grows older.

- I. Due primarily to changes in coagulation (continued)
 - C. Fibrinogen deficiency
 1. Congenital afibrinogenemia
 2. Acquired afibrinogenemia—severe liver damage

Laboratory findings:

- Prothrombin time—falsely prolonged
- Coagulation time—no coagulation
- Bleeding time—prolonged
- Clot retraction—no clot
- Sedimentation rate—no sedimentation of red blood cells

In this deficiency the prothrombin time is falsely prolonged. This anomaly is due to the fact that when a prothrombin determination is made, there is ordinarily sufficient fibrinogen present to produce a clot. In this condition in which the fibrinogen is decreased or absent, the prothrombin time is prolonged falsely even though the prothrombin content may be perfectly normal, as can be demonstrated by repeating the test diluting the patient's plasma with prothrombin-free plasma instead of physiologic saline. The coagulation time will be prolonged in cases of decreased fibrinogen and will never be completed when there is an absence of fibrinogen. The bleeding time, too, will be prolonged since clotting is either delayed or absent. If there is no clot formation, then of course there can be no clot retraction. The tourniquet test gives negative results, and the platelets are within normal limits. The sedimentation rate is of importance in this condition since the degree of sedimentation of red cells depends chiefly upon the amount of fibrinogen present in the plasma. The rate of sedimentation will be very slow or entirely absent.

The fibrinogen content of plasma can be determined accurately in a laboratory by the micro-Kjeldahl procedure or by several other methods. When there is no or very slight settling of the erythrocytes with the findings listed, an approximation of the fibrinogen content can be made by comparing the amount of coagulum formed on heating the patient's plasma and a normal control plasma to 65 C. in a water bath.

Afibrinogenemia, which fortunately is rare, can only be treated by transfusions of whole blood or plasma or the plasma fraction containing fibrinogen. This plasma fraction is available in vials containing 125 mg., and sufficient must be given to bring the plasma fibrinogen concentration up to 100 to 150 mg. per hundred cubic centimeters to prevent free bleeding. (Normal: 200 to 400 mg.)

- I. Due primarily to changes in coagulation (continued)
 - D. Circulating anticoagulants
 1. Administration of heparin
 2. Liberation of heparin
 - a. Shock
 - b. In some thrombotic processes
- Laboratory findings:
 - Prothrombin time—normal or prolonged
 - Coagulation time—prolonged
 - Bleeding time—normal or prolonged

The diagnosis of this disease is usually made without difficulty from the history of the administration of heparin or the clinical condition of the patient. It can be substantiated if prothrombin determinations are run on both the undiluted and 12.5 per cent plasma. A prolongation of the prothrombin time of the undiluted plasma out of proportion to that of the 12.5 per cent plasma indicates an increase in anticoagulant according to the work of Shapiro.⁷ It is readily realized that an increased amount of heparin requires an excess of thromboplastin to neutralize it; so in this condition, if enough heparin is present, the prothrombin time when undilute plasma is used will be prolonged as will the coagulation time. In the 12.5 per cent plasma, however, the heparin will be diluted out, but there is sufficient prothrombin to produce clotting and to give a more accurate determination of the prothrombin concentration. The bleeding time will be lengthened if the heparin is sufficiently concentrated. The clot retraction, the tourniquet test and the platelet count, however, are usually normal.

- II. Due primarily to decrease in the number of platelets
 - A. Idiopathic or primary thrombocytopenic purpura (purpura haemorrhagica)
 - Laboratory findings:
 - Bleeding time—prolonged
 - Clot retraction—poor
 - Tourniquet test—positive
 - Platelet count—markedly reduced
 - Leukocytes—insignificant alteration

The diagnosis of this condition is based upon the great reduction in the platelet count together with a prolonged bleeding time, poor clot retraction and positive reaction to the tourniquet test. Usually petechiae do not occur until the platelet count is reduced below 60,000 per cubic millimeter of blood. Even though the platelet count is markedly reduced, enough thromboplastin is released to bring about coagulation of the blood within the normal period. This also accounts for the normal prothrombin time. The bleeding time, however, is prolonged because even though the clot forms within the normal period of time, there are not enough platelets to fill in the interstices of the clot and to produce contraction. The tourniquet test in this disease usually gives positive results, either because of injury to the capillary wall or because there are not enough platelets to fill in small breaks in the capillary endothelium.

This type of purpura, which occurs most frequently in children and young adults, more commonly in the female than in the male, may appear

in the first year of life or may be present even at birth. It is characterized clinically by petechiae, ecchymoses and hematomas as well as hemorrhage from the mucous membranes. Bleeding may occur from the genitourinary tract. Profuse and prolonged uterine bleeding may be the only symptom of this disease at its onset. According to Sturgis,^{8b} when this condition occurs in the absence of purpura, the patients not infrequently consult the gynecologist, who should never overlook the possibility that menorrhagia or metrorrhagia may be associated with various types of hemorrhagic states. Bleeding may also occur from the alimentary tract or from the gums. Intracranial hemorrhage unfortunately is common and is present in most cases of this disease coming to autopsy. The spleen is palpable in about one third of these cases, but it is never large. There is no general glandular enlargement, no bone tenderness or evidence of any skin lesion of an urticarial nature.

It is essential that this disease be recognized for splenectomy is the treatment of choice and the earlier it is performed the better the prognosis. Before splenectomy is advised, however, the following diagnostic essentials listed by Wiseman, Doan and Wilson⁹ should be met:

1. There must be spontaneous purpura and/or free bleeding from the mucous membranes.
2. The blood platelets must be substantially decreased in numbers, that is, less than 100,000 per cubic millimeter of blood.
3. The clotting time and prothrombin time must be within normal limits.
4. The anemia and leukocyte count must not be out of proportion to the amount of bleeding.
5. There must be no pathologic cells in either the blood or the bone marrow.
6. There must be no recent history of the ingestion of drugs or the occurrence of those diseases known occasionally to produce thrombocytopenia.
7. There must be no appreciable enlargement of the spleen or lymph nodes.

- II. Due primarily to decrease in the number of platelets (continued)
 - B. Symptomatic or secondary thrombocytopenic purpura
 1. Blood disorders
 - a. Leukemia
 - b. Myelophthisic anemias
 - c. Aplastic anemia
 - d. Splenic disorders—Banti's syndrome
 2. Infections
 - a. Septicemias
 - b. Subacute bacterial endocarditis
 - c. Typhus fever

3. Allergic thrombopenia
 - a. Drug allergy
 - (1) Organic arsenicals
 - (2) Sedormid
 - (3) Benzol
 - (4) Gold salts
 - (5) Sulfonamides
 - b. Food allergy
4. Physical agents
 - a. Roentgen rays and radium

The laboratory findings are the same as for idiopathic thrombocytopenic purpura except that in blood disorders the anemia is out of all proportion to the blood loss. The blood count and bone marrow studies are of great value in this group of cases. If there is a leukocytosis, the probability of an infectious disease is likely. In the allergic states there may be an eosinophilia.

The history and physical findings are of great assistance in the diagnosis of this disease. A history of the administration of drugs such as those mentioned in the outline may be of help. Symptoms and signs of infection or of urticaria or erythema may be useful in differentiating this condition from the true idiopathic thrombocytopenic purpura. When purpura develops in an adult for the first time, one should search carefully for an etiologic agent, for a person with idiopathic thrombocytopenia rarely fails to have signs of the disease before reaching maturity. In these cases one should search most carefully for a chemical agent as the cause of the decreased platelet count. Treatment of symptomatic thrombocytopenia consists of treating the primary disease or of removing the offending drug, allergen, infectious or physical agent. The administration of vitamin C or rutin may help by increasing the capillary tone.

III. Due primarily to changes in the capillary walls

- A. Nonthrombocytopenic purpuras
 1. Infectious diseases
 - a. Subacute bacterial endocarditis
 - b. Typhus fever
 - c. Meningitis
 2. Allergic basis
 - a. Schönlein's and Henoch's purpura
 - b. Erythemas of Osler
 - c. Drugs
 - (1) Iodides, belladonna, quinine and snake venoms
 3. Vitamin deficiency
 - a. Vitamin C—scurvy
 - b. Vitamin P
 4. Toxins of nephrotic origin
 5. Abnormal capillary fragility of the newborn
- Laboratory findings:

Tourniquet test—positive

In all of these disorders the defect appears to be in the capillary walls and is due either to a toxin, allergen, drug or vitamin deficiency. Diagnosis depends chiefly on the tourniquet test. The

reaction to this test is positive in practically all instances, but there are instances in which capillary fragility is only a local and not a generalized lesion; so in those cases a negative result of the tourniquet test may be obtained at the usual site.

Nonthrombocytopenic purpura is the commonest type of purpura; it may occur in any infectious disease and is regarded as the characteristic rash in many diseases such as typhus fever, Rocky Mountain spotted fever and epidemic meningitis. The damage to the capillary wall in these instances may occur as a result of bacterial emboli lodging in the capillaries as in subacute bacterial endocarditis or by the direct action of a circulating toxin on the capillary walls.

Allergic purpura is common, the drug or allergen affecting directly the capillary wall. In Schönlein's purpura there is no hemorrhage into the joints as there is in hemophilia but rather a periarticular effusion which gives rise to pain and tenderness about the joints. The patient often complains of pains of a rheumatic nature. In Henoch's purpura the symptoms are referred chiefly to the gastrointestinal tract, and this form of purpura occurs most often in children and adolescents. The symptoms are due to an urticarial serohemorrhagic effusion into the intestinal wall, according to Wintrobe.⁹ Colic is the commonest symptom and may be transient or prolonged. Sometimes the abdominal symptoms are not accompanied by purpura, and many needless operations have been performed because this condition was not suspected. Henoch's purpura, like Schönlein's purpura, is often associated with rheumatic pain.

It is notable that the same disease condition may produce in one patient a symptomatic thrombocytopenic purpura and in another a nonthrombocytopenic purpura. In the first instance the toxin produces a decrease in the number of platelets and capillary damage while in the second instance the toxin acts only by damaging the capillary wall. Treatment in these purpuras depends upon treating the infection or, if it be on an allergic basis, upon eliminating the allergen or immunizing the body against it. Rutin and vitamin C are also used to improve the capillary tone.

- III. Due primarily to changes in the capillary walls (continued)
 - B. Congenital defective capillary walls
 1. Hereditary hemorrhagic telangiectasia

This disease, which is also called hereditary epistaxis, hereditary angiomas and familial telangiectasia, is a hereditary vascular anomaly due to multiple dilatations of capillaries and venules of the skin and mucous membrane which often gives rise to bleeding from these defective areas. This disease is transmitted as a mendelian dominant to either sex. Although the lesions may be observed in children, bleeding becomes more prominent as the patient gets older. Because this condition may be mild and never give rise to abnormal bleeding, one may get no history of its presence in other members of the family. Painstaking examinations will, however, usually reveal the presence of a lesion in one of the parents. Diagnosis is usually made by finding the triad of habitual hemorrhage, multiple telangiectases and family history. The tests ordinarily performed in the diagnosis of hemorrhage usually all give negative results. Treatment consists in stopping the hemorrhage, best by electrocautery, and by administration of iron or transfusion of whole blood if the hypochromic anemia is severe.

Summary

An effort has been made in this paper to present the physiology of hemostasis and the defects present in pathologic states. A classification of hemorrhagic states based upon a deficiency involving primarily either coagulation or platelets or capillary walls has been set forth. The pertinent laboratory findings in these different conditions are given together with an explanation as to the defect present and the mechanics of how this deficiency leads to bleeding. Stress is laid upon the necessity of attempting a diagnosis before beginning treatment. A few words are given in regard to treatment.

In conclusion, it might be helpful to classify the different hemorrhagic states based on the results of a few simple laboratory tests, as follows:

When one is confronted with a patient who has both a prolonged bleeding and coagulation time, one is probably dealing with either a prothrombin deficiency or in rare instances a lack of fibrinogen in the blood.

When there is a prolonged coagulation time with a normal bleeding time in a male, with reaction to other laboratory tests being negative, one is probably dealing with true hemophilia.

When one has a patient with a normal coagulation time and a prolonged bleeding time, but with clinical characteristics resembling hemophilia, one is probably dealing with pseudohemophilia.

When one obtains a normal coagulation time and a markedly prolonged bleeding time, together with poor clot retraction, and a positive reaction to the tourniquet test, one is probably dealing with either primary thrombocytopenic or symptomatic purpura. The platelet count is decreased markedly in both conditions. In symptomatic thrombocytopenia, however, the purpura is just a sign of a diseased state affecting platelet formation, and this condition must be strongly suspected in all thrombocytopenic purpuras beginning in older persons. In primary thrombocytopenic purpura the etiology is obscure, and the disease usually begins in childhood.

When only the tourniquet test gives positive results, one is probably dealing with a nonthrombocytopenic purpura.

When all of the laboratory tests give negative results, one should suspect hereditary telangiectasia or rhexis of a vessel from trauma or erosion.

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Principles of Medical Ethics as revised by the A. M. A. House of Delegates in June will be available in booklet form in the near future. See pages 302-306 for the comprehensive report of your Delegates to the A. M. A., Drs. Orr and Pearson.

General Allergies in Children

CHARLOTTE C. MAGUIRE, M.D.

ORLANDO

It is not the purpose of this paper to present a full discussion of allergy, but only to consider some of the allergies of children which are seen in pediatric practice. Not many years ago it was believed that allergic manifestations occurred only in adults, but today over half of the victims of allergy have been found to have had some allergic manifestations before the age of 5 years. The importance of early recognition and institution of adequate treatment for these allergic children cannot be overemphasized.

The term "hypersensitiveness" is used as an inclusive term to denote a state of specific sensitivity to a given substance. Allergy, meaning "altered reactivity," is used to denote sensitivity in the human. Synonymously with allergy the word "idiosyncrasy" has frequently been used.

Practically any substance may be an allergen and may produce an allergic reaction. Common allergens are classified as inhalants, ingestants, contactants, injectants and physical allergens.

There is not a satisfactory explanation as to why one person becomes allergic to a substance and others do not. The onset of allergy may occur at any age. As a rule, the more allergic the antecedents, the earlier will be the onset of the allergic manifestations.¹ Climatic conditions affect certain forms of allergy, especially the respiratory forms. Environmental conditions also act as contributory causes.

Body cells are believed to be endowed with a defense mechanism which protects them against harmful agents. The invasion of the body by bacteria or bacterial toxins (antigens) causes this defense mechanism to produce antibodies which are believed to facilitate the neutralization or destruction of invading bacteria. Body cells are apparently unaltered by the process of antibody formation and if subsequent bacterial or toxin invasion occurs, they again produce antibodies in exactly the same way. The same cellular process is thought to take place when an allergen first invades the body except that the antibodies (reagins) are believed to remain attached to some of the

tissue cells in localized areas. Thus these cells have been referred to as altered or sensitized cells. When the body is again invaded by the allergen, it is thought that there is a reaction between the allergen and the fixed antibody of the sensitized cells to such an extent that they liberate certain cellular constitutions, among which is histamine. Histamine has numerous actions, some of which are: contraction of smooth muscle (bronchiolar, intestinal and vascular), increased capillary permeability with hives and angioneurotic edema as a result, and increased activity of the glands of mucous membranes with copious secretions of mucus.

While tissues exposed to direct contact with allergens are most likely to react, others may also become involved indirectly. This involvement is particularly true of food allergy since a local reaction of the stomach and intestines does not prevent continued absorption of the offending substance. It is possible for one allergen to cause different symptoms in various allergic persons. It is also possible for one allergen to cause different manifestations in the same person on subsequent exposures, depending to some extent on the mode of entry as well as the reactivity of the various tissue cells.²

In hay fever and allergic rhinitis, the nasal passages become engorged and secrete copious amounts of thin watery mucus. The allergic nasal mucosa is especially sensitive to changes in temperature and humidity. It might be pointed out that an allergic mucous membrane is more susceptible and throws off infection less readily than a normal one. The converse is also true; a nasal membrane which is infected will respond less readily to allergic therapy. In asthma, the bronchi are constricted. This constriction is brought about because of edema of the bronchial mucous membrane, which edema narrows the lumen. There is obstruction also due to excessive amounts of mucus and spasm of bronchial smooth muscle. The many present day concepts of bronchial asthma have grown out of the introduction of skin tests to determine the skin reactivity to various protein substances. The important part played by the hered-

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ity factor is illustrated by the fact that a positive antecedent family history is found in approximately 80 per cent of the cases occurring during the first five years of life.

Food sensitization plays a more important role in children than in adults. Evidence accumulated has demonstrated that mold spores are of importance as contributory and even sole causes of allergic bronchitis. Air-borne fungi may be of importance in dry as well as damp climates, and outdoors as well as indoors. In one case of allergic bronchitis in which all trial and error elimination tests were without results, a positive scratch test for *Rhizopus* gave a clue, and it was found that the kapok pillows were harboring this offender. On removal of the pillows and a thorough cleaning of the entire environment of places harboring dust, the patient was symptom-free for three years. He then received one injection of penicillin, which immediately resulted in angioneurotic edema and subsequent dermatitis. Another case, that of a white boy 4 years of age who had increasing symptoms of asthma during midsummer months with the severity of allergic symptoms varying directly with the erythema of the skin as a result of a prolonged exposure to sunlight, demonstrates the activity of physical allergens.

That the skin is an important immunologic organ can be proved by the fact that antibodies are stimulated much more rapidly and in greater quantities if the antigen is injected intradermally than when injected intravenously or subcutaneously. The intradermal injection of 1 cc. of typhoid vaccine affords an example. In connection with allergic manifestations, the allergic antibody, or reagin, is essentially a skin-sensitizing antibody. It is for this reason that the skin is used extensively in diagnostic testing for sensitivity. Contact dermatitis involves the epidermis essentially, while eczema involves the corium. In children, secondary inflammatory changes in the skin occur, depending on duration, trauma and infection. The type of skin lesions seen in older infants and children, beginning at the twelfth to eighteenth month and continuing into late childhood is referred to as neurodermatitis; atopic dermatitis; atopic eczema and flexural eczema. Ingestants and inhalants are common sources of this type of dermatitis. Seasonal exacerbations are common in this form of eczema.

The results of treatment of neurodermatoses are often disappointing. Apart from the local and constitutional manifestations in dealing with chil-

dren, who frequently become self conscious and sensitive because of their unsightly appearance, the psychologic and emotional reactions may be such as to further increase an already existent nervous instability.³

Local treatment of eczema is generally futile. A complete detailed history of the case and an elimination program will insure more effective results. All sources of external irritations should be eliminated, as well as any suspected allergens; hence, scratch tests serve little or no purpose. There is perhaps no allergic disease in which the search for eliciting allergens is more discouraging.

Eczema occurring for the first time in persons past the period of infancy is not too unlike the contact dermatitis of adults, and these victims are not relieved always by restriction of foods to which the patient may or may not have a positive skin test. It is true, however, that the eating of certain foods aggravates the rash. Egg, milk, wheat, fish and, in infants, also orange juice and tomato, are the foods from which the most reactions are obtained.

Hospitalization is frequently necessary to clear some patients of eczema, and it, in many instances, recurs soon after the patient returns home. In such cases the actual change of environment which removed the patient from the offending contactants and inhalants was the basis of the relief of symptoms.

The manifestations of allergy of the gastrointestinal tract may be acute or chronic and may occur in the form of herpes labialis, swelling and burning of the lips and tongue, canker sores, distaste for food, distention of the intestinal tract, nausea, vomiting, abdominal cramps, mucous colitis, constipation or diarrhea, occasionally with bloody mucus stools, and pruritus ani. Colic in its widest application is used to describe any form of abdominal pain and is caused by either or both overdistention and forcible peristaltic contractions. The former is a result of swallowing air or excessive fermentation of undigested foods, especially carbohydrates. The painful peristaltic contractions may be the result of indigestion, intestinal distention, hunger, food allergy, or an instability of the autonomic nervous system. Breast-fed infants can suffer these gastrointestinal disturbances if they are sensitive to a particular food which the mother is eating. The artificially fed infant with a limited number of ingestants presents a much simpler problem, and the offending food can be detected with the aid of simplified trial diets.⁴

Gastrointestinal allergy is not necessarily a manifestation of food allergy. It may follow the inhalation of pollens. The strongest evidence of food allergy is the cessation of symptoms upon the elimination of the suspected food from the diet and a recurrence of symptoms whenever the food is again added to the diet. In some instances, certain allergens may produce a so-called "fixed sensitivity" and always initiate allergic manifestations when the patient comes in contact with the specific substance.

Since most allergens are protein in nature, it is possible frequently to change the antigenicity by heating or boiling the offending substances. Allergic children are frequently able to ingest milk after thorough boiling without showing evidence of any allergic manifestations.

The cutaneous tests are not wholly relied upon to unearth the clue to the exciting food allergy because the patient may show a negative skin reaction and yet be clinically hypersensitive. Again a patient may have a partial or complete tolerance to a food to which a positive skin reaction is obtained. As the child approaches about 7 years of age, food allergy ceases to be the predominant type of allergy, and then inhalants become predominant offenders. This may be illustrated by the fact that as the child grows older, positive skin reactions to food substances become less frequent.

The recognition of food allergy in patients not suffering also from asthma, hay fever, eczema, or urticaria is more difficult, and the clue to the allergic nature of the condition may be in the chronicity and lack of organic basis for the symptoms.⁵ In children the treatment of gastrointestinal allergy consists chiefly in elimination of the offending foods from the diet.

A routine procedure is the use of a simplified basic diet to which the child is least likely to be sensitive. This diet can only be formulated after a concise history has been obtained and the patient has been examined. After the allergic manifestations have subsided, I have been able to detect offending foods with considerable accuracy by the addition of only a single new food at each three or four day interval. Whenever an offending food is detected, it is withheld and tried again at some later date. Foods such as vegetables and meat soups, mixed fruits, eggs, wheat cereals, citrus, nuts and chocolate are not begun until the child has a substantial diet and is progressing satisfactorily otherwise. This method of procedure has been most satisfactory in gradually building up

the diet as required by growth and development of infants and has markedly reduced the incidence of allergic manifestations, especially gastrointestinal disturbances and the necessity of subsequent elimination diets.

In older children in whom the inhalants are the offending factors, environmental changes are frequently advisable. Physical allergies may be manifested in various ways. With exposure to the sunlight nasal congestion may result. Likewise, cold may cause allergic manifestations in susceptible persons.

Summary

The etiologic and pathologic aspects of general allergies in children are presented. Treatment is also discussed.

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Box 25.

Discussion

DR. THOMAS C. MAGUIRE, Plant City: Little did I dream when I graduated in medicine forty-one years ago that I would today, or at any other time, discuss a paper written and delivered by a sister-in-law of mine.

I wish to congratulate Dr. Charlotte Maguire for the concise manner in which she has presented this subject, "General Allergies in Children," in such a limited time.

When I began the practice of medicine the word "allergy" was not used in the sense of a medical term. We, at that time, called the allergic symptoms that we have today an idiosyncrasy to certain types of food or drugs, when urticaria and various skin lesions would appear.

The word allergy was coined by von Pirquet.

Historically speaking, a state of altered reactivity or allergy has been mentioned in the literature for the past two decades. In the early part of the nineteenth century an English physician traced his own attacks of asthma to his cat and would actually measure the distance between himself and the cat when his symptoms would appear.

The American Academy of Allergy came into existence about 1928, but it was not until eight or ten years ago that a separate section was established by the American Medical Association. Since that time allergy has been placed high in ranks in sections of internal medicine.

As Dr. Maguire says, any substance may be an allergen and produce an allergic reaction in many ways. Any patient having allergic manifestations is affected in various ways and is attacked when the body cells do not have enough antibodies to prohibit the growth of the invading bacteria. In the normal person the body cells are endowed with a defense mechanism which protects them from harmful invading agents.

Dr. Charlotte mentioned five types of allergens, namely, inhalants, ingestants, injectants, contactants and physical allergens. In my practice it has been the ingestants

that have given me the most trouble. I learned many years ago not to give by mouth or hypodermic any type of medicine when the patient said, "I can't take so and so." The medicines that have given me the most trouble are quinine, hyoscine, the arsenic group, and in recent years the sulfa drugs and penicillin.

It has been my privilege to treat many adults working in the citrus canning plants, who were allergic to the acids and oils from the fruits. The treatment is simplified in these cases by an application of some bland lotion and removal of the irritating substance. The skin lesions would clear up in a few days only to return if the patient returned to work. Many have had to stop this type of employment.

As to hereditary allergy, it is the allergic state that is inherited and not the manifestation. That is to say, if one parent should have the hives, it is the skin that is the

shock organ, but in the offspring the shock organ may be the nose or chest; therefore, the terms hay fever and asthma are applied. If one parent is allergic, then 35 per cent of the children will have allergic manifestations. Should both parents be so affected, then 85 per cent of their offspring will have allergic conditions.

Many of the foods that the mother eats pass through her milk unchanged. When one is treating babies with colicky pains, gas distention and various skin lesions, it is important to ascertain if the mother has any allergic symptoms. The process of food elimination with the mother, if she continues to nurse the baby, is most important, and in a day or two there will be a great improvement in the baby. The treatment is simplified with bottle-fed babies as changing the formula may often be the only requirement. Little medicine is necessary in these cases.

Clinical Response to Crowe's Vaccine in One Hundred and Twenty-Five Cases of Rheumatic Disease

KENNETH PHILLIPS, M.D.

MIAMI

Introduction

From the viewpoint of suffering, disability and cure, rheumatic and allied conditions may well assume the position of public enemy No. 1. In the *Primer on Arthritis*¹ the United States Public Health Service gives a 1937 prevalence in the United States of 6,850,000 for rheumatism, almost double that of heart disease, listed as 3,700,000.

A wide review of opinion, together with personal experience, emphatically accents contradiction of the statement by Tegner² that in 70 per cent of these cases there will occur spontaneous improvement. On the contrary, in the vast majority if left untreated, the condition will grow progressively worse and eventually leave the patient disabled and crippled. Any contribution which will carry additional relief to these masses should be desired. Reports from the Crowe, Charterhouse and Brighton Clinics in Europe, covering over 3,000 cases carefully analyzed since 1926, disclose a type of management available to individual physicians in their offices or clinics.³

Extensive inquiry reveals that several American physicians are using Crowe's vaccine with success; but knowledge of its value and clinical application is at present not sufficiently widespread. The clinical response in the 125 cases comprising this study fully justifies a report for

the benefit of the many physicians seeking methods which are applicable to the private office without special equipment. The various types of rheumatoid arthritis, osteoarthritis, myositis and fibrositis were included in the study; but extensive discussion of classification is avoided, and the scope is confined to the more important factors of symptomatic behavior and technic.

A further practical impression is gained from the reports of the European clinics in that a large number of the patients were indigent and unable to receive expensive radiologic, dental and bacteriologic examinations. They were, therefore, able to receive only the minimum extent of therapy afforded. A quotation from the report of the Brighton Clinic is significant: "No case, however crippled—and several were unable to get up the stairs or out of their chairs—has been refused."³ Both severity in disease and chronologic selection therefore are evident.

Methods of Study

The fundamental aim was to test clinically the value of Crowe's vaccine in a location geographically and climatically different from London. The same technical routine as described by the original investigators, together with their emphasis on dosage, was followed.

Proper therapeutic control was established in that while Crowe's vaccine was administered, all other treatment was restricted, except in cases in which the patient suffered from severe distress, when for a time moderate doses of analgesic drugs and sedative physical therapy were necessary adjuncts. When salicylates were used in this connection, low dosage (20 to 30 grains daily) was the rule. Since none of these adjuncts alone are curative, and many patients did not even receive them, the control is not clouded.

Cases were taken in chronologic order after diagnosis was established. The series consists of 125 cases. The age of the patients varied from 27 to 65 years. Sixty per cent were females and 40 per cent males. Subcutaneous injections of Crowe's vaccine, obtained directly from London, were given once weekly until clinical response was manifest; then the interval between injections lengthened according to behavior of symptoms. Examinations for progress were conducted at least monthly, and observation extended over eighteen months.

Technic of Management

Proper dosage of the vaccine and careful analysis of each patient's response are absolutely fundamental to successful treatment. Crowe is emphatic relative to this principle, and his contentions have been confirmed. The correct dose in any particular case may be high or infinitesimally low, and is not a matter of the slightest moment. The object is to provide a minimal stimulus to the immunity mechanism and avoid provocative reactions. This important viewpoint runs contrary to the thoughts of many physicians when dealing with vaccine therapy, in that there seems to exist an idea that the larger the dose the better the results. This false principle must be entirely eradicated, and failure to do so has been responsible for many negative results in the past.

The vaccine may be obtained from London in three forms; *Streptococcus* (200 strains), *Staphylococcus* (2 strains) and the mixed stock vaccines containing both. For the American physician the less technical method is to use the mixed vaccine, even though Crowe directs attention to its disadvantages over the use of the unmixed. While the present study has confirmed that the majority of the patients will respond equally well to the mixed vaccine, there will be a minor number for whom the separated stock solutions are needed.

Dosage is paramount. This observation is re-emphasized at the risk of repetition. For the purpose of simplicity, my associates and I carry a stock solution based upon 1,000,000 organisms per cubic centimeter as a unity. This lends to ease of making up treatment solutions by further diluting the original in multiples of 10. In our series the largest individual dose was 250,000; the vast majority were below 100,000. It is obvious, therefore, that working solutions must be made up and kept on hand containing 0.1, 0.01 and so forth strengths of the unity, in order that proper individual doses can be calculated and given with ease.

We begin with an initial dose of 25,000 to 50,000 depending upon the severity of symptoms. Children over 5 years of age receive the same dose as adults. This initial dose is lower than that used by the London groups, but it has worked well in our hands. All subsequent dosage is calculated upon the individual response of the patient, which brings us to the important discussion of response and reactions. Their recognition and importance cannot be overemphasized.

Pause for a moment to reflect the difference between this scheme of dosage and that advocated for the run of American stock vaccines, usually 5,000,000 as an initial dose. No wonder that Pemberton⁴ could only admit the value of vaccines in "some cases." He advised injections every five to seven days in doses ranging from 10 million to 2,000 million.

Three terms must be clearly defined, and carefully apprehended: response; reaction; and relapse.

Response means an immediate improvement following an injection of the vaccine. It must not, however, be preceded by an aggravation of symptoms. If it is, then reaction has ensued, and the dose must be reduced according to prescribed formula.

Reactions may be of four kinds, and the dosage must fluctuate accordingly. Local reaction (at the site of injection) usually means an error in technic; either a breach of antisepsis, or the vaccine has been given too deep, piercing the fascia. No change in dosage is indicated. Focal reaction refers to an exacerbation of symptoms, especially pain, swelling or tenderness in the parts involved. It calls for reduction in dosage. General reaction is not uncommon; it must be recognized and properly managed. Lassitude, severe exhaustion and often a dull and vague type of

headache are the commonest manifestations, although anorexia, slight nausea or night restlessness may be exhibited. This likewise calls for reduction in dosage. In our series when general reaction occurred, it did so with predominance within twenty-four hours after the injection, although it may occur later. Lag reaction is a peculiar type, but must be carefully sought because it is frequently missed by the patient. It consists of no subjective response to symptoms for a few days, and then a subsequent improvement. It is thought that a mild type of general reaction has been threatening; and unless dosage is reduced, a severe general reaction may take place following the subsequent dose.

Relapse may be defined as the tendency of symptoms to recur after previous improvement following the injection has been noted. It may be manifest three to ten days after the injection. It is often difficult to distinguish from lag reaction, but differentiation is emphatically necessary since the alteration of the dosage is directly opposite.

It is obvious that, for successful treatment, the physician must cross examine and before calculating any dose determine the answer to three questions relative to the previous injection: 1. Was there any obvious effect of the injection? 2. If so, was it good or bad? 3. What days or nights in relation to the injection did the effect occur? Invaluable aid to this phase can be obtained by supplying each patient with a printed diary slip covering six days and nights. The response is recorded daily, and the slip brought along for survey by the physician at each injection.

For clarity and importance the scheme of dosage following the initial and each subsequent injection is as follows: response, continue the same dose or increase; local reaction, no change in dosage; focal reaction, reduce each dose one half; general or lag reactions, reduce dose tenfold; relapse, same dose or slight increase.

These are the keynotes to results, and one must not hesitate to continue reduction of dosage if reactions continue, even down to dilutions in which an individual dose is only 100 as compared to an initial 50,000 unit injection.

Clinical Results

One cannot avoid being favorably impressed with the symptomatic response of rheumatic disease to this treatment. The London group venture the word "cure" and tabulate accordingly. It has

purposely been avoided in this report. The rheumatic group, in which has been included patients with rheumatoid arthritis, osteoarthritis, fibrositis and myositis, represents a horde of people suffering from distress and disability for which there is, at present, no treatment sufficiently satisfactory. Any measure which is sufficiently simple to be placed at the disposal of the physician in general office practice and will produce this degree of improvement must not be denied.

Table 1 reveals an over-all response which has emphatically relieved 90 per cent of these sufferers from their distress and disability sufficient to re-establish them to comfortable living and earning status. These end results were, frankly, surprising to me. It is both a security and an additional satisfaction to know that the cases were individually scrutinized, and personal contact with both American and European physicians using the management has established equally enthusiastic results.

Three cases of uric acid diathesis were included in the series because of the amount of generalized bodily distress manifested. In all, response was favorable, but it is not believed that this would in general hold true, since Crowe reported little or no benefit in these cases.

Difficulties Which May Be Encountered

Sensitiveness of the patient to both the vaccine and the disease constitutes one of the leading likelihoods of difficulty. It is characterized by a worsening of the symptoms, and when its occurrence is subsequent to an injection of vaccine, it may be confused with a typical reaction. Controversy in thought exists relative to how much allergy is tied up in the rheumatic syndrome. When it is present, probably the protein fraction of bacteria is concerned. Sensitivity may develop suddenly during the early weeks of treatment, and if not immediately recognized, trouble may be experienced and the disease actually made worse. Careful regard must always be paid to any signs of general reaction following the vaccine and a tenfold reduction made in each subsequent injection, even to the low level of 100 units of vaccine per dose. Ample evidence has accumulated to verify the hypothesis that with increasing dosages in the presence of sensitivity the resistance of the host can actually be decreased while that of the invading organism is increased. This, of course, would

Table 1

Analysis of Clinical Results in 125 Cases Treated with Crowe's Vaccine

Classification	Number of Cases	Average Duration	Results			Duration of Treatment * Average
			Pain	Swelling	Function	
			No Change or Worse	Moderate Improvement	Much Improvement	
Nonarticular rheumatism including myositis, fibrositis and neuritis	44	2½ years	2—4.5 %	6—13.63%	36—81.8%	8 weeks active
Rheumatoid arthritis	56	6 years	6—10.7 %	9—16.7%	41—73.2%	6 months active
Osteoarthritis	22	7½ years	4—18.18%	8—36.3 %	10—45%	14 months intermittent
Uric acid diathesis	3	8 months	0	1—33.3 %	2—66.6%	10 months active
						18 months active
						6 weeks active
Total	125		12—9.6 %	24—19.2 %	89—71.2%	

* Active treatment indicates weekly injections; intermittent treatment, bimonthly, monthly or even longer intervals between injections.

result in actually defeating the purpose of the management.

A common stumbling block, therefore, is the bacterial content of the very small dose. How could this content, for example, in a dose of 0.00001 million, or an equivalent of say 10 organisms, of a vaccine containing 200 strains, possibly be of any value? Yes, in a few cases it has been necessary actually to dip down to this level, and the clinical response has been evident. The answer is that the method of preparation is such that the majority of the organisms are autolyzed and in solution. To clarify further this confusion, I have chosen to adopt the term "units" in place of "organisms." The mathematical calculation of strength and dose is exactly the same, but the new terminology eradicates the mental puzzle.

When excessive sensitivity is manifest toward the vaccine, Crowe directed attention to the value of using benzamine lactate or procaine mixed with the vaccine at the time of administration. He reported that the mechanism is not at present understood.

Crowe was of the opinion that sensitiveness arises under four conditions: autoinoculation (improper amount of physical activity during the acute stage); focal infection; gross infection of staphylococcal origin; and idiosyncrasy. All are important and are discussed in detail in his writ-

ings. Discussion of them here is, however, precluded by the space limit of this report, except to accent that in the presence of obvious focal infection one should raise the immunity level with the vaccine prior to surgical correction.

The proper interval between injections, and the length of time to continue treatment are natural questions. Intervals of from five days to one week in the beginning have been our policy, and it has worked well. This schedule is continued until definite relief of symptoms is obtained; then the interval is lengthened until symptoms are under control, at which time the active treatment is stopped. Patients should be cautioned to report back immediately upon any sign of relapse to have injections resumed until they are again symptom-free. It is not uncommon to find patients requiring a single injection every two or three months in order to keep relapse in abeyance. For this reason I prefer to avoid the term "cure."

General Discussion and Summary

Many phases of this management, although significant, cannot be discussed in detail because of limitation of length. They are fully described in other reports and may be obtained by reference. There is no doubt that if properly supervised, this vaccine management of rheumatic disease affords an ambulant therapy which is available and effec-

tive. Opinion is strong that in the hands of those experienced in the method it is superior to any other single type of treatment. Sufficient data have now been collected to justify its establishment on its own merits, and henceforth there is no reason why its use should be restricted or confined to the vaccine alone. It can and should be used to augment any other facility which has been proved of benefit.

I am at present using it in combination with physical therapy, intravenous colloidal sulfur, gold therapy, vitamins or salicylates; and the results indicate that even more beneficial results will be obtained. It is noteworthy to observe that the same principles, relative to reaction and dosage, as outlined for the vaccine can successfully be applied to gold therapy.

In diseases of this nature, where thousands are

stricken down and disabled and no established treatment is as yet sufficiently satisfactory, we as physicians have no moral right to become dogmatic and prejudiced, thus depriving these sufferers of any proved adjunct. Crowe's vaccine management does supply an additional aid, especially since it is an ambulant treatment, is simple, and is applicable in the office of the general practitioner with no additional equipment required. A plea is made for its use.

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ABSTRACTS OF MEDICAL ARTICLES

THE USE OF RADON OINTMENT IN THE TREATMENT OF LATE IRRADIATION ULCERS. By David Kirsh, M.D., J. Francis Mahoney, M.D., and Eugene P. Pendergrass, M.D. Am. J. M. Sc. 212: 395-403 (Oct.) 1946.

Late radiation ulcers, occurring months to years after radiation has been employed, usually follow infection or trauma of a minimal nature to an area showing the stigmas of previous radiation. As a result of a diminished blood supply in the tissue, an ulcer forms which is indolent, painful and tender; it may become gangrenous and undergo malignant degeneration. The pain may be so intense that the patient may become a victim of drug addiction and be a total invalid.

In a series of 17 cases, 19 late irradiation ulcers were treated with a new therapeutic agent—radon ointment—in the Department of Radiology of the Hospital of the University of Pennsylvania. Twelve of the ulcerations were completely healed after from three to fifty weekly applications. Two lesions with residual malignant involvement showed a good response, but failed to heal completely.

Their favorable results with this method of treating late radiation necrosis, while not as uniformly successful as those obtained by

Uhlmann, led the authors to believe that Uhlmann's introduction of alpha particle therapy is a new approach and a definite advance in the nonsurgical treatment of what has been a particularly discouraging clinical problem. One of the most striking features they noted was the prompt relief of pain when its use was combined with methods for control of the concomitant infection. Too, the change in the mental outlook of the patient was most gratifying, for definite evidence of healing was observed in some instances one week after institution of treatment. They warn, however, that its potential dangers, both for the physician and the patient, should be appreciated and that the material, when not in use, should be stored under lead protection.



ROENTGEN MANIFESTATIONS IN THE SKULL OF METASTATIC CAROTID BODY TUMOR (PARAGANGLIOMA), OF MENINGIOMA AND OF MUCOCELE, A REPORT OF THREE UNUSUAL CASES. By Eugene P. Pendergrass, M.D., and David Kirsh, M.D. Am. J. Roentgenol. 57: 417-428 (April) 1947.

In the 3 unusual cases reported the underlying lesions were a metastatic carotid body tumor, a meningioma and a mucocele. In all, unilateral

exophthalmus and osteolytic lesions of the skull were present. Despite the similarity of the clinical manifestations, however, the diagnoses, histories and roentgen appearances differed widely. The various studies are discussed in detail, and an effort is made to emphasize differential diagnostic criteria.



THE ROLE OF IRRADIATION IN THE MANAGEMENT OF CARCINOMA OF THE BREAST. By Eugene P. Pendergrass, M.D., and David Kirsh, M.D. *Radiology* 51: 767-778 (Dec.) 1948.

Inclusion in this report of all cases of carcinoma of the breast seen from 1932 through 1939 brings up to date a previous report on material covering the years from 1902 through 1931 in a prolonged study carried out at the Radiologic Clinic of the Hospital of the University of Pennsylvania. The present data include a five year follow-up on a number of cases in which surgical treatment alone was employed. Classification, definition of terms, various types of irradiation, and irradiation technic are discussed, and data are set forth in numerous tables. The incidence of five year survivals in successive periods indicates that the increase in the survival rate from 26 per cent in the early period to 42 per cent in the latest period is significant, reflecting such probable factors as both earlier and improved therapy, surgical and radiologic, and better selection of cases suitable for operative care.

Of the 406 cases included in the latest survey, there were 350 in which the patient was subjected to surgery and 56 in which irradiation alone was used for various reasons. Postoperative roentgen irradiation to the operative site and lymph node areas was carried out in 188 cases, while in 162 there was no irradiation therapy except when metastatic or recurrent disease developed. It is noteworthy that 141 private patients sought medical aid an average of 7.4 months after the apparent onset of the disease, 127 ward patients 9.3 months, and 20 Negro patients 12 months.

In summary, the survey of the 350 cases revealed no significant improvement in the five year survival rate which could be attributed to postoperative roentgen therapy. The role of irradiation in the palliative management of such cases is discussed. The relatively high incidence of herpes zoster, 16 cases or 4 per cent occurring in 406 patients, is regarded as probably due to metastatic involvement of the spinal ganglion.

STUDY OF URETERAL BLOOD SUPPLY AND ITS BEARING ON NECROSIS OF THE URETER FOLLOWING THE WERTHEIM OPERATION. By John P. Michaels, M.D. *Surg., Gynec. & Obst.* 86:36-44 (Jan.) 1948.

In view of the general consensus that the vexing problem of ureteral fistula which often follows the Wertheim operation arises chiefly from a disturbance of the blood supply of the ureter incurred during this operation, a study was made of the ureteral blood supply in relation to the operation. Fourteen ureters in 7 infants were dissected after arterial injection of a liquid latex mass, and the blood supply as found is described.

Prophylaxis is regarded as the best treatment for this complication. In addition to a proficient knowledge of the normal and abnormal anatomy of the ureter, meticulous and gentle dissection of the ureter from its bed is advised, with the use of every precaution both to preserve the periureteral arterial plexus and to dissect out carefully and preserve the blood vessels to the ureter. The latter, it is observed, are also to be avoided during pelvic lymphadenectomy. The avoidance of other contributing factors such as mass ligation and the use of drains too close to the ureter is discussed. To increase the blood supply to the ureter as an additional prophylactic aid, hypogastric block or resection is suggested.



STUDY OF THE DISAPPEARANCE OF CONGO RED FROM THE BLOOD OF NON-AMYLOID SUBJECTS AND PATIENTS WITH AMYLOIDOSIS. By Paul N. Unger, Morris Zuckerbrod, Gustav J. Beck and J. Murray Steele with the technical assistance of Yetta Porosowska. *J. Clin. Investigation* 27: 111-118 (Jan.) 1948.

A method is described whereby the disappearance of congo red from the blood was studied in 74 subjects, 10 of whom were healthy young adults; 52 had rheumatoid arthritis and the remaining 12 had various diseases. The authors concluded that the use of congo red for testing for the presence of amyloidosis was simplified and the accuracy was increased in their study by calculating the theoretic initial concentration rather than using a two or four minute specimen for comparison and by using thirty minutes rather than an hour as the end point. They also noted that T-1824 (Evans blue) cannot be used for the calculation of blood volume in amyloidosis because amyloid tissue fixes this dye also.

THE PROTHROMBIN RESPONSE TO THE PARENTERAL ADMINISTRATION OF LARGE DOSES OF VITAMIN K IN SUBJECTS WITH NORMAL LIVER FUNCTION AND IN CASES OF LIVER DISEASE: A STANDARDIZED TEST FOR THE ESTIMATION OF HEPATIC FUNCTION. By Paul N. Unger and Shepard Shapiro with the technical assistance of Shirley Schwalb. *J. Clin. Investigation* 27: 39-47 (Jan.) 1948.

In a series of 57 cases without clinical evidence and 56 cases with such evidence of disease of the liver, a standardized vitamin K tolerance test estimating the prothrombin response to the parenteral administration of large test doses of vitamin K was used. The results were correlated with other hepatic function tests, and in 24 of the 113 cases of the series there was morphologic study of the liver.

The vitamin K tolerance test exhibited excellent correlation with other clinical findings indicative of impaired function of the liver referable to various causes and proved to be a sensitive indicator of hepatic function. Since it was established as one of considerable sensitivity for measuring the hepatic function of prothrombin formation, it is suggested as a good index of the presence or absence of hepatic disease.

HYPERPROTHROMBINEMIA INDUCED BY VITAMIN K IN HUMAN SUBJECTS WITH NORMAL LIVER FUNCTION. By Paul N. Unger, M.D., and Shepard Shapiro, M.D. *Blood* 3: 137-146 (Feb.) 1948.

The purpose of this study was to learn whether it is possible to induce hyperprothrombinemia in human subjects with normal liver function by the administration of large doses of menadione derivatives. Thirty-eight persons were studied in two groups.

The conclusion was that reduction of the prothrombin time of diluted (12.5 per cent and 8 per cent) plasma below normal occurred in man with normal liver function following parenteral administration of large doses of menadione derivatives. In each case, when the increase was demonstrable, it continued for transitory periods only, lasting twenty-four to forty-eight hours. In the opinion of the authors, the greater magnitude of the change exhibited by increased dilution of the 8 per cent plasma as compared with the 12.5 per cent supports their belief that the shift in the direction of hyperprothrombinemia is functional and not an apparent change produced by mathematical manipulation of the data.

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The American Druggist Surveys British State Medicine

The American Druggist is to be congratulated on its July 1949 issue, which is devoted to British State Medicine. Editor McPherrin traveled the British Isles with a radio recording machine to learn firsthand the mixed emotions of the public, studied the British chemists' reaction, learned how the British system works and discovered that few Britons comprehend the high cost of free medical care. He came home "with new reverence for the faith of mankind that created America," convinced that there is no hope, peace of mind or real security for anyone in the belief that "The State is my Shepherd, I shall not want." This false concept with its mesmeric appeal, core as it is of the Welfare State idea, has done something, he observes, to the British spirit, for to the extent that any man accepts the doctrine that the State alone can bring him security and happiness, he loses faith in himself.

What happens when the state undertakes to pay the doctor's bills, as Great Britain is at present finding out, is explained in an article prepared for this special issue by Richard Denman of the staff of the London Economist. Not only is the Health Service costing far more than was estimated, but there is also constant pressure to make it cost still more. Furthermore, the limit of what the government can raise in taxation to meet it has already been reached. The average citizen knows little about the cost, and even less about how it can be paid by the British people. Attempts are made to curb supply rather than demand to control cost; thus, for example, many hospital beds, greatly in demand, have had to be closed.

Cutting practitioners' fees is another means of reducing expenditure, as dentists and opticians have already found out.

Health insurance actually pays but 12 per cent of the stupendous cost of the Health Service, by far the greater part, therefore, being met from general taxation. Besides the insurance contribution of about \$1 weekly per worker, each of the 13 million British families pays \$81 yearly in addition. In other words, of every pound (\$4.03—now devalued to \$2.80) spent on the Health Service, \$3.52 is paid by taxation, and only 52 cents comes out of the insurance contribution.

This analysis serves to emphasize that no one yet has ever devised a method by which the public can get something out of government for nothing. This British precedent should expose the deception implicit in the current propaganda in this country for "painless payments" extracted from every worker's pay envelope for compulsory government health insurance.

Whither Would You Flee?

Is Aneurin Bevan, British Minister of Health and leader of the left wing of the Labor Party, a good prophet? Said he recently to an American editor, "The method we are using to provide health for the people will spread all over the world. In modern society, it is inevitable. America must come to it."

American physicians are opposed to state medicine and compulsory health insurance primarily because they are convinced they cannot render the best medical care under this system.

The new system of "quickie doctor care" in Great Britain is making it more than difficult for the English physician to practice the brand of medicine he has been taught. The overworked general practitioner can allow no more than four minutes per office call before a warning buzzer speeds the patient on his way. One reads of a Welsh physician treating 115 patients in little more than three hours, and another in Glasgow seeing 194 on a busy day.

A disgusted former British physician, who recently left a profitable practice in Britain to begin a new professional life in this country, fled the "degradation" of socialized medicine because it is "prostituting the medical profession." His experience convinced him that British physicians are "forced to operate under regimentation at its very worst." Said he:

Doctors in Britain are under an economic bludgeon. Either a doctor takes so many patients and must cover so much territory that he can give only inadequate attention to each, or the doctor has only a few patients whom he can treat adequately but who do not afford him a living.

I could not keep on under a system that made it physically impossible for me to be a good doctor. There were days when I saw 20 patients in an hour at the office, and one day I made 36 house calls. What happens is that the physician with many patients works himself to death. . . . One woman who imagined that she had a secret ailment called at the office twice daily for weeks.

From London comes the farewell letter of a family doctor, off to New Zealand. He wrote in part:

It is difficult to describe the mixture of feelings which this move engenders. Many of my friends have congratulated my wife and myself on our courage in uprooting our lives and going thousands of miles to make a fresh start. I do not share that view. On the contrary, I am haunted by the doubt as to whether there is not a touch of cowardice about it.

We are used in this country to fighting on doggedly against long odds, and it is a hateful feeling to have to admit defeat.

On the other hand, even if I continued the struggle, I should not be at peace with my own conscience, because I should know that as I became more and more tired, my work would steadily deteriorate, and I should be less and less capable of living up to the standards of service that have been instilled into me. . . .

I have been trying to cope with 2,200 patients, but I should need double this number to keep my children in school. Before the health act I averaged 25 to 35 visits per day, which represented 45 working hours per week. Since the act my visits average 55 to 80 per day, sometimes 100, and my working hours 70 and 80 hours per week. No medical man can work these hours, coupled with broken nights, and continue to give efficient service.

Mass production and bureaucracy in medicine simply do not make sense. The effect of the scheme has caused a general practice to become a heartbreaking struggle for the doctor who tries to maintain a high standard, and the ultimate result must inevitably be a lowering of the general standard. . . .

The present system is a failure because the public has been promised services beyond the power of the medical profession to offer. Because it is paid for by a compulsory levy on incomes, it appeals to the worst side of human

nature and tempts the man in the street to get as much as he can out of it.

Whither would you flee, Doctor, from the degradation of socialized medicine, were it allowed to blight the land of the free and the home of the brave, as Aneurin Bevan predicts?

The Nation's Daily Disaster

Chronic illness is a problem of such magnitude, complexity and universal scope that a Commission on Chronic Illness was recently organized to cope with it on a public as well as an individual basis. Addressing the commission, Dr. Leonard Scheele, Surgeon General of the United States Public Health Service, styled chronic illness the nation's daily disaster and declared that creation of the commission marked a historic turning point in the care of the chronically ill in this country.

It is generally conceded that at present more than 60 per cent of all deaths are due to chronic disorders. The true proportion appears to be much higher, however, for life insurance figures indicate that in 1945 the chances of ultimately dying of chronic disease were 81.6 per cent as against 53.5 per cent in 1901. In addition to mortality data, morbidity, degree of disability and duration of chronic invalidism are equally important criteria. Though data regarding them are few and largely unsatisfactory, total invalidism involving bed or institutional care represents but a small fraction of the total load of disablement, dependency, suffering, lost productivity and economic loss engendered by long term illness. Partial impairment of efficiency of personnel not sick enough to be absent, but who accomplish but a fraction of their potentiality because of chronic impairment of health, from anemia, for example, or hypertension or neglected cholecystitis, probably accounts for losses many times greater than those attributable to actual time lost.

Long term illness is perhaps the most urgent, the most important and the most complex problem before medical science and practice today. Its sociologic importance hardly needs emphasis. Organization of the Commission on Chronic Illness is therefore timely, and it is fitting that it is being officially sponsored by the American Medical Association, the American Hospital Association, the American Public Health Association and the American Public Welfare Association. All four groups have contributed financially to the support of the commission, and the American Medical Association is also offering the new group office space in its Chicago headquarters.

**A. M. A. Clinical Session
December 6-9, 1949**

The nation's capital will this year be host to the Clinical or Interim Session—the third annual mid-year meeting—of the American Medical Association on December 6-9. A full scale scientific program designed to be especially attractive to the general practitioner will be featured, and a special effort will be made, through promotional mailings to physicians within a 500 mile radius of Washington, to induce general practitioners living in that area to attend.

Outstanding physicians in their respective fields will discuss such subjects as Diabetes, Pediatrics, Laboratory Diagnosis, Physical Medicine and Rehabilitation, Arthritis, Dermatology, X-ray Diagnosis, Cancer and Poliomyelitis. Approximately 100 scientific exhibits, presenting original work on these subjects, will be coordinated with the scientific program. In addition, the newest offerings of 125 manufacturing firms will comprise the Technical Exposition. Throughout the three and a half day session the exhibit hall will be open so that ample opportunity will be afforded for study of the developments in scientific medical research, drugs and equipment which constitute the latest contributions to modern medical practice.

Annual Grass Roots Conference

The Sixth National Conference of County Medical Society Officers, popularly known as the Grass Roots Conference, is scheduled for Thursday evening, Dec. 8, 1949, at the Hotel Statler in Washington, D. C. This conference is sponsored by the Board of Trustees of the American Medical Association and is carried on by county medical society officers. All registrants for the American Medical Association Clinical Session and their wives are invited to attend.

"Outstanding Achievements in Community Medical Leadership" is the theme for the meeting this year. Leaders who are qualified by personal experience will describe these achievements that have been taking place throughout the nation.

A. M. A. Clinical Session**Dec. 6-9, 1949****Washington, D. C.****Duval County Medical Society
New Auditorium Opened**

A notable milestone of progress was reached by the Duval County Medical Society on October 4 when its members formally opened the auditorium which is the first unit of its new home. Facing the St. Johns River at a convenient location between Lomax Street and Bishop Gate Lane in Jacksonville, the building was recently completed at a cost of \$52,000 and will seat 400 persons. Wings will be added later to provide conference rooms, a medical library, a medical museum and suitable facilities for a doctors' exchange and public information service. Also, the present temporary porch will be replaced by a foyer.



Sellers Auditorium, Jacksonville—the new home of the Duval County Medical Society.

The auditorium has been named Sellers Auditorium honoring Dr. E. Thomas Sellers, chairman of the society's building committee. When Dr. Sellers was president of the society in 1935, he and other medical leaders of Jacksonville foresaw the necessity of having suitable quarters to house the group's activities. A committee headed by Dr. Robert B. McIver was accordingly appointed to survey the need and the means whereby this dream might be realized. The present building committee, active since 1944 under the chairmanship of Dr. Sellers, is composed of Dr. McIver, Dr. Ernest W. Veal, Dr. Shaler Richardson and Dr. Banks H. Goodale.

The gala occasion opened with the society's regular monthly meeting, Dr. Raymond R. Kilinger, this year's president, presiding. The Rev.

C. F. H. Krueger, brother of the late Dr. Frederick W. Krueger, who was a member of the building committee, was introduced by Dr. Goodale and offered the invocation. Dr. Killinger then turned the meeting over to Dr. Charles F. Henley, chairman of the program committee, who presented the guest of honor, Dr. Walter C. Payne of Pensacola, President of the Florida Medical Association. Dr. Payne graciously felicitated the society on this first step in the achievement of its goal of a complete home and paid homage to Dr. Sellers. He then formally dedicated the Sellers Auditorium.

Dr. Henley then introduced Dr. Webster Merritt, able historian and Assistant Editor of The Journal, who presented the highlights of the history of medicine in Duval County by reviewing briefly his book, entitled "A Century of Medicine in Jacksonville and Duval County," published by the University of Florida Press in July of this year. This authentic and engaging account of the development of the Duval County Medical Society from its inception is an equally fascinating story of Nineteenth Century Jacksonville and was a subject peculiarly appropriate to the occasion. The talk was enhanced by quaint illustrations of other years.

At its conclusion, Dr. Merritt called the roll of past presidents as their names were thrown on the screen, and they stood in a body for recognition. When the name of Dr. Robert H. McGinnis, president from 1904 through 1907, was called, he came from his hospital bed to be acclaimed by the gathering and he presented to Dr. Sellers a check for \$500 for the building fund. Dr. Merritt then turned to the future, recognizing Dr. James L. Borland, who succeeds to the presidency in 1950, and came back to the present, recognizing the present president, Dr. Killinger.

Dr. McGinnis' brother, Mr. Eugene C. McGinnis of Raleigh, N. C., was accorded a warm welcome and appropriately thanked for the beautiful flowers received with his compliments. Acknowledgement was also made of other floral tributes.

At the conclusion of a brief business meeting, the members, their wives and the other guests, under the guidance of the genial and efficient entertainment chairman, Dr. Robert M. Baker, repaired to the riverfront grounds to enjoy a barbecue supper and social hour under the auspices of the Woman's Auxiliary.

Refraction Offer Investigated

Recently, various Florida physicians have received a flattering offer for refraction work with no experience necessary. The postal card communication quoted bears a Chicago postmark of Aug. 12, 1949:

Dear Doctor:

Can offer you a permanent arrangement requiring your full time services away from your office. Arrangement is not in your town but is in your state. The work is refracting patients for glasses that we recommend to you. Refracting experience preferred, but not necessary. Office space is provided. Arrangement pays a definite guarantee of \$300.00 per month with an opportunity to make up to \$500.00 a month. No outside calls, and no evening work.

If interested and available, wire or write me at once, and I will make further arrangements with you. Please advise if you are registered in any other states.

Thanking you for your prompt reply, I am

Sincerely yours,
A. Fisher
1148 W. Chicago Avenue
Chicago 22, Illinois

Phone: MOnroe 6-2148

The Editor of The Journal, on inquiry, received from the Bureau of Investigation of the American Medical Association the information that the address on this card is that of the Ritholz Optical Company and that the Ritholz firm has used a variety of individuals' names in sending out its "come-on" material. A review of the activities of this concern was published in the Journal of the American Medical Association, Feb. 15, 1941 (Vol. 116, page 597) under the title of "Physicians Offered a 'Deal.'" The concluding paragraph of this editorial follows: "By engaging repeatedly in such practices, these concerns have shown their total disregard for the welfare of the American people and their desire to make a profit at the expense of the eyesight of the citizens of this country. Their effrontery in attempting to engage unsuspecting physicians to promote their activities is astounding. An ethical physician would not give the slightest consideration to alining himself with such an outfit."

In 1941, physicians in the Indiana area were being offered an "attractive opportunity and fine remuneration" by "B. Sherman" at this same Chicago address. The Bureau of Investigation first dealt with the Ritholz optical concerns in 1925 (J. A. M. A., July 25, 1925) and ten years later reported under the title of "The Ritholz Frauds" a post office fraud order issued against the firm, which used at that time some nine different trade styles. For a time the facilities of Chicago newspapers and radio stations were barred to these

stores, until the Ritholz concern eventually agreed to advertise in accordance with the standard practice of optometrists (J. A. M. A., July 6, 1935). Later, two law suits involving the National Optical Stores and Benjamin D. Ritholz were reported (J. A. M. A., Dec. 11, 1937, page 2015, and July 1, 1939, page 88).

In 1934 and in 1937, Benjamin D. Ritholz of Chicago, doing business under several trade names, was the object of complaints of the Federal Trade Commission, and a fraud order of the Post Office Department, in connection with the promotion of dental plates and spectacles. In March 1936, Ohio physicians received from the address of the Ritholz Optical Company building the offer of "an unusual proposition for an oculist" with remuneration of "at least \$40.00 per week." A card signed by "B. Sherman" and mailed from Louisville, Ky., on Sept. 28, 1936 also proposed an "attractive opportunity netting at least \$40.00 per week" for a physician in Louisville. The State Department of Health of Kentucky stated at that time this man represented the National Optical Stores Company of Chicago. It would appear that Florida is now the latest outpost of activity and that the remuneration has increased in keeping with the times.

"What Is the A. M. A.?"

Under the title of "What Is the A. M. A.?" an interesting and constructive article appeared on October 11 in *Look* magazine, which has a readership of 19 million. Have you read it? It was written by the popular medical editor, Harold B. Clemenko, and is a six page documentary picture story, which is one of the most comprehensive ever published about the American Medical Association in a lay magazine. Not only officials of state medical societies throughout the country but also every physician in the nation would do well to take personal interest in this article and its wide dissemination. The profession would no doubt benefit greatly from maximum circulation of this excellent public relations article.

The article is definitely a tribute to the individual doctors, county societies and state associations as well as to the trustees and officers. Reading it gives one a much clearer knowledge and understanding of the American Medical Association, its functions, its purposes and its contributions. Highlighted are the over-all officers and the work of every bureau, council and committee, drama-

tized in pictures under appropriate captions; the ten outstanding achievements of the organization; and the twelve point program.

To facilitate widest distribution of this article, Dr. Robert B. McIver, Secretary of the Association, telegraphed the secretaries of the county medical societies, and Dr. Joseph S. Stewart, Chairman of the Committee on Public Relations, also sent a telegram to the chairman of the public relations committee of each of these societies, directing their attention to it. Reprints are being made available through the headquarters office in Jacksonville, for it is expected that the individual members of the Association will wish to cooperate in disseminating this constructive public relations material as widely as possible.

Report of Delegates to A. M. A. Convention Atlantic City, June 6-10, 1949

The Ninety-Eighth Annual Session of the American Medical Association recently held in Atlantic City was the second largest in the history of the Association. Total registration revealed more than 13,000 physicians and almost 15,000 visitors in attendance. More than 400 physicians from foreign countries were stated to be present, evidencing the international interest in the Association. Never in the history of the organization have the exhibits and sectional meetings been so well attended. There were 212 registered scientific exhibits and 341 technical exhibits. More than 300 scientific papers were presented and discussed at the scientific sections. The television program in color in the huge auditorium attracted more than 30,000 interested visitors.

Dr. Ernest E. Irons of Chicago was inducted into the Presidency of the Association. By unanimous vote, Dr. Elmer L. Henderson of Louisville, Ky., formerly Chairman of the Board of Trustees, was made President-elect. Dr. Louis H. Bauer of Hempstead, N. Y., was re-elected to the Board of Trustees and by virtue of the election became Chairman of the Board.

On Sunday prior to the opening of the meeting, there were many meetings of great interest. One of the most outstanding was an open religious service addressed by Francis Cardinal Spellman, Rabbi Morris S. Lazaron and Rev. Joseph McCartney. On Monday evening, a dinner for the House of

Read and approved at a meeting of the Board of Governors, Jacksonville, Sept. 18, 1949.

Delegates was addressed by Lord Horder, physician to the King of England. At the same time, the Joseph Goldberger Award in Clinical Nutrition was presented, posthumously, to Dr. Randolph West of New York City.

During the period of the Session, there were more than twenty radio interviews and newscasts under the sponsorship of the Association.

The first meeting of the House of Delegates was called to order by the Speaker, Dr. F. F. Borzell of Philadelphia, at 10:10 a.m. on Monday, June 6. The actions and decisions by this body were of great significance and might well mark this Session as being one of the most important in history. The pronouncements made by the House of Delegates were made in full realization that this was only the beginning of the fight to preserve free enterprise according to the American way of life.

The first order of business was the selection of the recipient of the Distinguished Service Award, which after two ballottings went to Dr. Seale Harris of Birmingham, Ala.

The address of the Speaker of the House, Dr. F. F. Borzell, is thought to be of such importance as to warrant reprinting in this report. It is as follows:

Gentlemen:—Since the Interim Session at St. Louis last December, the American Medical Association has been the pivotal point of many charges and discussions. Its officers have been attacked both from within and without. We have been accused of holding our membership behind an "Iron Curtain." The officers and Board of Trustees have been called a hierarchy made up of reactionaries committed only to the maintenance of a "status quo." It has become necessary for our officers to make public denial and even direct refutation of these charges even to the membership of Congress.

It is because of the events of the last six months that this session of the House of Delegates of the American Medical Association assumes proportions of great significance, not only to the medical profession but to the entire nation as well.

This House of Delegates, constituting for the most part the elected representatives of the membership of the constituent state associations, took deliberate and unanimous action on several matters of vital consequence to the American people. We were accused of having set up a "slush fund." This charge was made with implications of intent to apply pressures corruptly on our legislators for our own selfish ends. If there is one responsibility that is outstanding on this session of the House of Delegates, it is that its deliberations must show the American public once and for all that the American medical profession, constituting the American Medical Association, is a completely democratic body and that when the House of Delegates speaks it speaks for the vast majority of American physicians. It must further demonstrate more clearly than ever that its motivations spring solely from a sense of primary responsibility to insure for our people the maintenance of a quality of medical service equaled nowhere else in the world.

As an answer to criticisms of adverse publicity arising from the St. Louis session, your Speaker respectfully requests this House of Delegates to authorize the appointment for this session of a special committee of five mem-

bers of the House to be known as the Committee on Publicity whose function will be to cooperate with the Department of Press Relations of the American Medical Association to the end that releases may be made expeditiously and authoritatively. The Speaker has discussed the mechanics of operation of this proposed committee with Mr. John Bach, Director of the Department of Press Relations, and believes that such committee offers a practical solution to the problem.

A better understanding of the democratic functioning of this House might perhaps be stimulated if the delegates would invite selected members from their state societies who are in attendance at the scientific sessions to observe at least one meeting of the House.

The Speaker wishes to take this opportunity to thank the many delegates who have by letter and personal communication shown a keen desire to fulfill their important duties.

It is apparent that this House is faced with a continuing necessity of giving extended consideration to social and political problems dealing with the nation's health. On the other hand, it is noteworthy that while so much emphasis has of necessity been placed on these problems, our scientific activities have been carried on without relaxation through *The Journal*, other publications of the Association and the various councils and bureaus. We must, therefore, continue to look to the delegates from the various scientific sections to keep the House alerted to scientific matters requiring action.

At the St. Louis session several resolutions were presented with multiple endorsements. The Speaker is of the opinion that the intent of such resolutions would be better served if they were presented by a single endorsement and the supporters appeared before the proper reference committee in support. This not only will save time and be more democratic but also will more effectively record approval. Your responsibilities are such that your deliberations must be accurately reported and be given correct interpretation to the public. You therefore must continue to assume full responsibility, individually and collectively for your actions. This responsibility demands that we guard every move we make lest we fail in upholding our proud traditions and the lofty position we have attained.

In periods of great stress, in the heat of battle, human reactions are intensified and irritations magnified. It is difficult to retain the calmness necessary for good generalship. Righteous indignation may easily be transmuted into blind hatred. The former is a source of strength, the latter an evidence of weakness. The eyes of the country are on us. Our comrades in arms, the great medical profession, are looking to us of the House of Delegates for leadership. We, then, must lead and not be led. Pressures stimulated by vindictiveness, base emotions or self interest dare not activate our conduct.

He whom the Gods would destroy, they first make mad. There are those who would gladly destroy the American Medical Association, but as long as we hold to a course of dignity, singleness of purpose and unwavering solidarity, we can win. Gentlemen, your responsibility is great and in your hands rests the health of this nation.

Attention is directed to the address of President R. L. Sensenich, which may be read in the June 18 issue of the A.M.A. Journal on page 612.

A report of Committee on Liaison with Red Cross Blood Banks revealed that there would be thirty-four Red Cross Blood Centers in operation by July 1, 1949. Officials of the Red Cross have reaffirmed their support of the policies established by the American Medical Association House of Delegates and promise their continued cooperation to abide by these policies.

The summary dismissal of Dr. Morris Fishbein as Editor of the Journal of the American Medical Association was contained in a tersely worded statement released by the Board of Trustees through the Chairman, Dr. Elmer L. Henderson.

In view of the increasing responsibility of the Editor and reorganization of the department, the Board of Trustees has decided on the following points:

1. The Editor will completely eliminate speaking on all controversial subjects both by platform and by radio. Approval of all speaking engagements will be made by the Executive Committee.

2. Elimination of all interviews, including press conferences, and statements by Dr. Fishbein except on scientific subjects.

3. Editorials on controversial subjects will be supervised by the Executive Committee.

4. Complete information as to these activities will be reported to the members of the House of Delegates.

5. There will be permanent elimination of the diary in Tonics and Sedatives.

6. Plans for the training of a new Editor in an orderly manner, including the retirement of the present Editor, will be formulated.

Editorial comment from some of the largest of the nation's newspapers were, for the most part, in sympathy with the action taken, but a careful reading of a section of an editorial will clearly show the lack of intelligent understanding by even supposedly well informed editorial writers. From one large daily, normally conservative, a section of an editorial is as follows:

The imminent possibility of national compulsory health insurance has now jarred most doctors from complacency. They believe government medicine will endanger the advance of medical science and research, undermine high standards of medical care. Yet, even with the issue joined, it has taken time to convince the rank and file that the Fishbein methods—negative opposition and vituperative propaganda—were ill suited to combat the lures of government paternalism. Most accepted the \$25 assessment levied to exploit those methods, but skepticism as to their efficacy spread until even Dr. Fishbein was constrained to support at least a pro forma health improvement program sponsored by doctors. The dramatic muzzling of Dr. Fishbein leads the public to expect changes in the reactionary policies he epitomized. And we believe that is the correct interpretation of the Trustees' action. For if, as some doctors are charging, Dr. Fishbein is merely a scapegoat sacrificed to counter criticism while the policies which merited criticism remain unchanged, the public's disillusion might well do more harm to the doctors' cause than could Dr. Fishbein.

The readings of the reports of the Reference Committees began on Tuesday afternoon, June 7, and their actions and approval by the House were in many incidences of momentous importance. The House of Delegates reaffirmed the position of the Association relating to membership in the American Medical Association, and the resolution by the New York delegation for the appointment of a special committee to study certain conditions involving membership was disapproved by the reference committee. The committee restated that the manner of admission to membership is entirely a county society function, and unless the constitu-

tion and by-laws were amended, an appointment of such a committee would serve no useful purpose. The committee unanimously recommended that this resolution be rejected. The report of the committee was approved by the House.

The Council on National Emergency Medical Service reported that the position of the Surgeon General of the Army had been elevated so that the Surgeon General reported directly to the Chief of Staff. The House expressed satisfaction and commended the Council on helping to bring about this elevation status. Audience was granted Surgeon General Raymond W. Bliss of the U. S. Army, and Surgeon General Clifford A. Swanson of the U. S. Navy, who addressed the House at length.

Dr. Henderson, Chairman of the Board of Trustees, spoke on the subject of the World Medical Association and pled for increased membership of the United States Committee. Dues for membership are \$10 a year. He stressed the fact that all members of the House should participate in the work of this great organization.

The House approved the creation of a Section on Physical Medicine and Rehabilitation. A change in by-laws made this effective.

The addresses of Mr. Clem Whitaker and Miss Leone Baxter, of the firm of Whitaker and Baxter of the Public Relations Council for the A.M.A., made before the House is recommended for careful study. Copies of the addresses can be found in the June 25 issue of the A.M.A. Journal on page 694.

It is recommended that the Report of the Reference Committee on Reports of the Board of Trustees and Secretary, as published in the A.M.A. Journal of July 2, page 794, be carefully studied. In this report it was concluded that it is illegal, with some minor exceptions, and unethical for any lay corporation to practice medicine and to furnish medical service for a professional fee, which shall be so divided as to produce profit for a lay employer, either individual or institutional. The statement brought forth the view that hospital service plans shall provide payment for hospital services only and that medical service plans shall provide payment for all medical services, including pathologic, roentgenologic, anesthesiologic and physical therapeutic services. Every physician on the appointed staff of the hospital, the committee believed, should have a voice in its professional management. The conclusion was that most controversies between management and the professional staff should be settled on local levels and

that every constituent state and territorial society shall appoint a committee on hospital and professional relations.

The committee further found that it was within the power of the Judicial Council to find a hospital or lay group guilty of violating the principles of ethics and recommended that the Judicial Council order the withdrawal of the Association's approval of the hospital that did not comply.

The Council on Medical Service restated that the American Medical Association is in no way engaged in the insurance business and has no intention of giving a preferential treatment to one type of voluntary plan. The Association does, however, evaluate insurance plans with a view to protecting people against unscrupulous and unsound plans. The Council further recommended the formation of a National Coordinating Agency to represent all qualified voluntary prepayment plans. The Council recommended that there should be no official connection between the American Medical Association and the Associated Medical Care Plans, but that the Associated Medical Care Plans should be recognized as a trade organization of member plans and the Blue Cross as a similar trade organization for the voluntary hospital care plans. These recommendations were approved by the House after considerable discussion.

The Council on Medical Service recommended and presented for adoption twenty principles for lay sponsored voluntary health plans which are as follows:

1. The plan shall be nonprofit, paying no dividends to beneficiaries or others; all surplus earnings shall be devoted either to improving the services, to making compensation of physicians and other staff members more adequate for their responsibilities and services, to purchasing facilities and equipment, to increasing the scope of benefits, or to building adequate reserve funds. All income to the plan shall be devoted to services for beneficiaries.

2. The plan shall comply with the Principles of Medical Ethics of the American Medical Association, which provide that it is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body, or individual employing him.

3. If incorporated, the plan shall be adequately financed and organized without capital stock.

4. The plan shall be operated under an autonomous administration or trust, with segregated funds, and shall be devoted exclusively to the provision of health service.

5. Promotion, sales, organization and administrative expense of the plan shall be kept at a minimum as judged by the accrediting body.

6. The quality of medical service shall be maintained at the highest possible level. All participating physicians shall be doctors of medicine duly licensed to practice medicine in any state in which the plan operates. Each physician engaged in the practice of a specialty shall be required to have adequate qualifications for that specialty.

The personnel and facilities of the plan shall be adequate to insure a high quality of medical care.

7. The plan shall provide all services as set forth in the agreement with the beneficiary. When, in the opinion of the medical staff, a professional service set forth is not available because of an emergency or because of the need for highly technical procedure, or for any other reason, then such service shall be otherwise provided by the plan.

8. The plan, in its agreement entered into with the beneficiary and which shall be distributed to each beneficiary, shall state clearly the services and benefits to be provided and the conditions under which they will be provided. All exclusions, limitations, waiting periods and deductible provisions shall be clearly stated in the agreement with the beneficiary and in promotional and descriptive literature.

9. The plan shall, in its agreement with the beneficiary, state clearly the amount of dues or subscriptions to be paid. The amount of dues or subscription shall be adequate to provide for the benefits and services offered and to insure proper financing of the risks involved.

10. No promotional material shall invite attention to the professional skill, qualifications or attainments of the physicians participating in the plan.

11. Participating physicians may be compensated in any manner not contrary to the Principles of Medical Ethics of the American Medical Association relating to contract practice.

12. Any duly licensed physician in the community who wishes to participate in the plan, who meets its professional and personnel standards and who agrees to abide by its terms and the requirements of its beneficiaries shall be admitted to the plan.

13. The names of all participating physicians of the plan shall be made available to the prospective beneficiary. The beneficiary shall, within reasonable geographic and professional limitations, have free choice among participating physicians.

14. There shall be no interference by the governing body with the medical staff in the practice of medicine. The traditional and confidential relationship of the physician and patient shall be preserved.

15. Adequate provision shall be made for effective participation of the medical staff in the deliberations of the governing body. It is recommended that the membership of the governing body include representatives of the medical profession.

16. All services rendered by the participating physician, not included in the beneficiary's contract, shall be payable by the beneficiary to the participating physician on a fee for service basis.

17. The method of operation of any hospital owned or under contract to the plan shall be in accordance with sound public policy.

18. The plans shall provide for like rates, benefits, terms and conditions for all persons in the same class.

19. Investment of reserve funds shall be made only in securities deemed prudent for such purposes.

20. Any plan desiring approval under these principles shall agree to such periodic reviews and to abide by such regulations as may be deemed necessary by an appropriate accrediting body of the American Medical Association in consultation with representatives of the sponsors of the plan.

After a lengthy hearing and due consideration, the twenty points were adopted by the House of Delegates. The objections of the New York delegation to the final criterion that "any lay sponsored plan desiring approval by a proper accrediting body of the American Medical Association shall come bearing the endorsement of state or county medical association involved" was overwhelmingly defeated and the twenty points were adopted as a whole.

The House supported the resolution on Medical Education and recommended that a Postgraduate education should be made more widely available for general practitioners and that two year rotating internship should be especially designed for those who wish to train for general practice, and finally that the American Medical Association should most urgently insist that hospitals make freely available to qualified general practitioners all their facilities for the care of the sick.

The resolution suggesting the abandonment of the Annual Award of the medal to the leading general practitioner was defeated and the House of Delegates will continue this Award.

The Coordinating Committee of the Association reported that they decided to employ the firm of Whitaker and Baxter as campaign managers, not only because of their general reputation, but because they are familiar with the problems of compulsory health insurance. The committee then decided to organize a committee of fifty-three, representing each state and territorial medical association.

Whitaker and Baxter now report over 1,000 organizations now on record against compulsory health insurance. Twenty-five million pieces of literature have been mailed out. Two million five hundred thousand pieces of literature have been mailed direct from Whitaker and Baxter and not from state associations. For the information of all members, let it be known that there is no limit to the amount of material which will be mailed to any state association or individual, so long as it can be used effectively. Besides state associations and individual physicians, all endorsing organizations received the literature.

The Reference Committee on Insurance Plans and Medical Service reported on the resolution on Blue Shield coverage of the American Medical Association employees, to the effect that the committee has found the plan employed for servicing the employees of the American Medical Association one of the several approved by the Illinois State Medical Society. While this plan is not a Blue Shield Plan, it was recommended to the Board of Trustees by a committee of the employees after due consideration. There has been no evidence presented to your committee of any dissatisfaction among the employees effected. The committee believed that any choice between two approved plans, a decision of the local parties involved should be upheld. It further believed

that every sincere effort was made to carry out the directions of the House of Delegates. It therefore recommends that the House of Delegates hereby rescind the action of June 23, 1948, wherein it said, "Your committee recommends, because of the above stated opinions, that at the expiration of the present contract of hospital and medical health coverage, the American Medical Association through its proper officials, make every sincere effort to procure this coverage for its employees through the Blue Cross-Blue Shield local organization. Your committee understands that this coverage is, and will be, available by substituting for the words "Blue Cross-Blue Shield local organization" the words, "any approved voluntary health insurance plan." This recommendation was approved by the House of Delegates without discussion.

The Judicial Council presented to the House of Delegates a restatement and revision of the Principles of Medical Ethics, which was promptly adopted by the House of Delegates. Many significant changes which will bear close reading are included in the revision. Some of these changes refer to groups and clinics, including contract practice. A section on Educational Information and a section on Purveyal of Medical Service should be given careful study. The Principles of Medical Ethics will become available in the form of a newly designed booklet which may be obtained from the office of Secretary, George F. Lull. It is suggested that the secretary of each component medical society obtain a number of copies of the new Principles of Medical Ethics and that at some appropriate meeting these Principles be read aloud to each society.

Both your delegates attended all sessions of the House of Delegates with the senior delegate serving on the Judicial Council and the junior delegate serving as a member of the special Reference Committee on Insurance Plans and Medical Service.

Respectfully submitted,
Louis M. Orr, II
Homer L. Pearson, Jr.

A. M. A. Clinical Session

Dec. 6-9, 1949

Washington, D. C.

Florida Legislature

The regular session of the 1949 State Legislature is now history and the Committee on Legislation and Public Policy desires to express appreciation to the Committees on Legislation of the county medical societies, and to many individual physicians who gave valuable advice to their personal friends in the legislature. Evidence of the effectiveness of local doctors contacting their legislators was demonstrated many times during the session. Special commendation is due Dr. Walter C. Payne, president of the Association and ex officio member of the Committee on Legislation and Public Policy. During the early days of the session Dr. Payne stayed on the job in Tallahassee until such time as the Chairman was able to assume this responsibility.

As in the past the 1949 session of the legislature witnessed an avalanche of bills, and for almost any conceivable proposal. A total of over 2700 bills were introduced into the Senate and House of Representatives, although many were identical measures submitted to both houses. Directly or indirectly a considerable number of the proposed measures related to public health or public medicine. Some few of these were good, some questionable and others definitely detrimental to public interest. Only a small number became laws and these appear for the most part to be beneficial, and none particularly objectionable. Below is listed a summary of certain measures enacted into law by the 1949 legislature which have a bearing on the practice of medicine in the state.

Chief among the defeated proposals was House Bill 508 which would have denied to naturopathic physicians permits for hypnotic and narcotic drugs (see editorial in August issue of Journal).

Also listed as casualties were House Bill 706 intended to clarify the type of signs required to be displayed by practitioners of the healing arts at their places of business, and House Bill 717 which would have authorized an assistant secretary to the State Board of Medical Examiners, who need not be a doctor of medicine. Likewise lost in the pathetic confusion of the closing days was Senate Bill 267 designed to make unlawful certain types of rebates on specified items and services. House Bill 808 requiring distinctive containers for so-called household poisons passed both houses but was vetoed by the Governor.

With even our limited experience certain observations were manifest. Medical doctors not

only can exert a powerful influence for the passage of sound health legislation, they will be definitely considered negligent in their duty if they fail to do so. This is a legitimate function of the Florida doctors and is effective and beneficial to the public in the extent of activity on their part. Legislators not only will listen attentively to the doctors from their own communities, they are actually, with few exceptions, eager to have professional advice on matters pertaining to health and medicine. Our open and straight-forward methods are gaining the respect and confidence of the law-makers.

Results show that obtaining sound statutes is not a task just for the period when the legislature is in session. It is a year round job, every year. There is little use to approach our elected officials without a unified, constructive program, presented to them well in advance of the session. Our program should be virtually complete by the spring of 1950, not 1951. County medical societies contemplating submitting proposals should have them in the office of the Secretary of the state association well in advance of the 1950 annual convention to allow time for study and analysis. It is essentially useless to wait until the 1951 convention for approval of desired legislation and expect to have a legislature already in session to act favorably upon such bills.

In the meantime talk to your senator or representatives whenever the opportunity presents itself. Explain the evils of government interference in the private practice of medicine, be it state or federal. All dangerous legislation of this nature isn't in Washington. A bill was introduced into the past session of the Florida Legislature to add cash sickness benefits to the workmen's compensation act. It was killed in committee. If you believe that your legislators have been doing a good job, and most of them have, they will appreciate having you tell them so.

Eugene G. Peek, Sr., Chairman, Committee on Legislation and Public Policy



ENACTING CLAUSES OR SYNOPSIS OF CERTAIN LAWS PASSED BY THE 1949 LEGISLATURE

Amending section of Workmen's Compensation Law pertaining to Medical Services and Supplies—Chapter 25244, No. 248, H. B. No. 660: an act to amend Section 440.13 of Chapter 440, Florida Statutes of 1941, requiring doctors to furnish to injured employees a copy of their medical reports of examination or treatment of workmen's compensation cases. The law now requires that physicians shall furnish to the injured employee, on demand, a copy of each report.

Amending Florida Statutes relating to misbranded drugs—Chapter 25239, No. 243, S. B. No. 413: amphetamine has been added to the list of drugs which may not be sold at retail other than on a prescription signed by a duly licensed member of the medical, dental, osteopathic, naturopathic or veterinary profession.

Providing for regulating the practice of medical technology—Chapter 25069, No. 73, S. B. No. 180: an act defining and regulating the practice of medical technology and for the examination and licensing of medical technologists and technologist directors. Administration of this act is by the Board of Examiners in the Basic Sciences and enforcement is by the State Board of Health. Exempt from its provisions are licensed practitioners of the healing arts; technicians employed by such practitioners or by any hospital where the technician is under the supervision of a healing arts' practitioner; technicians of the government services, state board of health and similar agencies.

An Act to create and establish the School of Medicine and Nursing at the University of Florida at Gainesville—Chapter 25249, No. 253, S. B. No. 329: Section 1—There is created a school of medicine and nursing at the University of Florida to be located on University of Florida campus at Gainesville and to be a component part of the University. Section 2—The University of Florida schools of medicine and nursing shall be coeducational and shall be so maintained and operated as to comply with the standards approved by nationally recognized medical and nursing associations for accredited schools of medicine and nursing.

Amending sections relating to medical and/or hospital service plans—Chapter 25394, No. 398, H. B. 828: amending the enabling act for medical and hospital service plans to make them subject to regulation and supervision by the insurance commissioner of the State of Florida and all provisions of laws of Florida applicable to health and/or sick or accident insurance.

Authorizing the compulsory isolation and hospitalization of certain persons infected with tuberculosis—Chapter 25241, No. 245, S. B. No. 550: provides for the compulsory isolation in State maintained sanatoria of persons afflicted with tuberculosis, who in the opinion of competent medical examiners are adjudged dangerous to other persons, and who refuse voluntarily to isolate themselves and provide for proper treatment.

Amending certain sections relating to Bureau of Vital Statistics—Chapter 25372, No. 376, Committee Substitute for H. B. 560: amended to include stillbirths and to make confidential information on birth certificates which would disclose illegitimacy. A short form of birth certificate is provided which is available to any applicant, and which contains only the name, color, sex, date of birth, place of birth, date of filing of original certificate and the certificate number which shall be certified to by the State Registrar. Disclosure of illegitimacy or of information from which it can be ascertained may be made only upon order of a court of competent jurisdiction. Certified copies of the original birth certificate or any new or amendatory certificate, exclusive of that portion containing medical details and legitimacy status, shall be issued only by the State Registrar and only to the registrant, if of legal age; his or her parents or guardian; to approved health or social organizations and government agencies. These restrictions do not apply to marriage, divorce or death records.

Providing more adequate medical and psychiatric personnel for mental institutions operated by the State—Chapter 25374, No. 378, H. B. No. 423: the board of commissioners of state institutions is authorized and directed to employ with all reasonable promptness a chief psychiatrist and such other additional psychiatrists as needed. They shall be attached to the medical staff of the Florida State Hospital at Chattahoochee and shall have fully recognized and accredited training and experience in the practice of medicine and psychiatry. The chief psychiatrist must be a graduate of a class A medical school (as classified by the American Medical Association and the Association of American Medical Colleges).

An act providing for the construction of a building at the Florida State Hospital at Chattahoochee—Chapter 25373, No. 377, H. B. No. 687: to be used as a psychiatric treatment ward; providing for the equipping and furnishing same; providing for employment of personnel to operate same; making appropriations therefore.

An act authorizing the establishment and operation of a hospital for the care and treatment of chronic alcoholics—Chapter 25371, No. 375, H. B. No. 187: providing the procedure for the commitment of chronic alcoholics to said hospital; the cost of such proceedings and treatment; duties of county judge; the discharge of said alcoholics; levying an additional tax on certain alcoholic beverages; and appropriating the proceeds of said tax to carry out the purposes of the act.

YOUR BLUE SHIELD

Payment of Blue Shield Cases

In recent months it has come to the attention of the Blue Shield Plan that there has been an increase in the number of cases in which payments to physicians for services rendered Blue Shield members have been delayed. In an endeavor to

devise a system whereby Blue Shield payments to physicians could be made more promptly and to determine the causes of delays in the payment of some cases, a study was recently made by the Plan on cases paid.

Origin of Claims

This study revealed that one of the reasons for delay in payment is the fact that a number of physicians are not originating the claims. This should be done by sending into the Plan the completed Doctor's Service Report at the time services are rendered. Information received from physicians as to why these reports were not completed at the time the services were rendered indicates that they did not know that the patients were Blue Shield subscribers. It would seem that the answer to this problem would be for the doctor, or his secretary, to ask each patient if he is a Blue Shield subscriber and request that he present his Blue Shield identification card.

Claims that are not originated by physicians are originated by the Plan from information received either from the subscriber or from Blue Cross hospital billings. (Under this system the necessary forms are sent by the Plan to the physician for completion.)

The study made by the Plan disclosed that the source of origin of Blue Shield cases affects prompt payment in the following ways:

Claims originated by participating physicians are approved for payment in an average of fifteen days after the date of surgery.

Claims originated by the Plan are approved for payment in an average of twenty-nine days after the date of surgery.

Complete Information on Doctor's Service Report

Once a case has been originated, it falls into one of two categories. Either the Doctor's Service Report has been submitted in its complete form and can be immediately processed, or further information must be requested from the physician. In cases where it was necessary for the Doctor's Service Report to be returned to the physician for further information, the Plan found that the loss of time involved amounted to fourteen days.

In cases for which payments were delayed for further information, the Plan found that the majority entailed questions relative to the subscriber's income status, whereby either the income level of the subscriber as indicated on his Blue Shield identification card had not been shown on the

Doctor's Service Report, or the fees charged for services rendered were not in keeping with the patient's income level.

Delays in approval for payment also result from insufficient information in reference to the services rendered. In many cases the Plan must request the participating physician to furnish more detailed information about a particular procedure, or furnish the code number of the procedure performed.

Prompt Payment of Cases

To assure physicians of prompt payment on all Blue Shield cases, it is suggested that the following procedure be adopted:

1. Originate the claim by sending into the Plan the completed Doctor's Service Report immediately after services have been rendered.

2. Include on the Doctor's Service Report complete information pertaining to (a) patient's income level, (b) code number of surgical procedure performed, and (c) detailed information on complicated surgical procedures.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

Cleland D. Cochrane of Daytona Beach, local Kiwanis Club
Jerome A. Megna of Ft. Pierce, local Lion's Club
Joseph S. Stewart and John D. Milton of Miami, local Council of Business and Professional Women's Clubs
Cleland D. Cochrane of Daytona Beach, local Lion's Club

DEATHS

Deaths—Members

Dr. Waldo Horton, Winter Haven Aug. 22, 1949
Dr. Young C. Lott, Miami Aug. 22, 1949
Dr. Robert C. Woodard, Miami Aug. 31, 1949
Dr. Raleigh R. Sullivan, Lakeland Sept. 11, 1949

Deaths—Other Doctors

Dr. Grover C. Franklin, Miami Aug. 18, 1949
Dr. Dan Hardie, Miami Sept. 22, 1949

STATE NEWS ITEMS

Dr. Louis A. Wilensky has returned to Jacksonville, after spending a year in New Orleans, and will resume the practice of ophthalmology and otolaryngology in the near future at his old offices in the Professional Building.

Dr. James R. Nieder of Delray Beach has returned from North Carolina, Washington and New York City, where he visited hospitals and clinics.

Dr. William C. Roberts of Panama City addressed the regular monthly meeting of District 22 of the Florida State Nurses Association, September 12 at the Bay County Health Center, on the subject "The Future of Nursing."

Dr. Roland W. Banks of Wauchula spoke before the Arcadia Kiwanis on September 9, on atomic energy and medical research. Dr. Banks dealt chiefly with the use of atomic energy from a purely medical standpoint, as applied to scientific research and medical treatment.

Dr. Wesley W. Wilson of Tampa has returned to his office after attending a meeting of the Southeastern Dermatological Association in Atlanta.

Dr. Mozart A. Lischkoff of Pensacola was appointed by President Payne to represent the Florida Medical Association at the Second National Conference on Physicians and Schools, which was held at Highland Park, Ill., on October 13, 14 and 15.

Dr. James F. Henry has announced the opening of his offices in the Phillips Professional Building, Winter Haven, for the practice of medicine. He is associated with Dr. William W. Hardman.

Dr. Harrison G. Palmer of St. Petersburg has returned to his practice after visiting clinics in Washington, New York, the New England states, Montreal and Ottawa, Canada.

The Council on Industrial Health will hold its Tenth Annual Congress on Industrial Health at the Roosevelt Hotel in New York City, February 20 and 21, 1950.

Your Membership in SOUTHERN MEDICAL ASSOCIATION IS VALUABLE



The Campbell-Kenton County Medical Society of Kentucky is the host Society. It is a Kentucky meeting.

THE VALUE OF MEMBERSHIP IN MEDICAL ASSOCIATIONS AND ATTENDANCE AT MEDICAL MEETINGS

SUCCESS, whether measured by achievement, confidence gained, or by monetary standards, comes largely through achievement and maintenance of competence. A physician, like persons engaged in other fields of endeavor, must keep abreast of the latest developments and methods in his field in order to maintain competence.

THE SOUTHERN MEDICAL ASSOCIATION was founded in 1906 for the purpose of developing and fostering scientific medicine and surgery in the South and in its forty-three years of existence has never deviated from this objective. Through attending the annual meetings of the Southern Medical Association and by reading The Southern Medical Journal, thousands of physicians of the South are taking an important step toward achieving and maintaining their competence in the constantly changing field of medicine.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there is always a program at the meeting and articles in the Journal to challenge that interest.

THE MEETING this year will be composed of thirty-two sessions of the twenty-one sections, two General Clinical Sessions and two conjoint meetings. Eligible members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$5.00 include the Southern Medical Journal, a journal that should be a "must" on every physician's reading list.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
BIRMINGHAM 3, ALABAMA

Dr. Matthew Arnow of Eustis recently opened offices for the practice of medicine in Williston.

Dr. Clarence D. Rollins of Jacksonville has returned to his practice after attending a three weeks' course in obstetrics and gynecology at the Woman's Clinic of the University of Chicago.

Dr. Manuel A. Schofman of Miami has completed postgraduate work in the study of the ear, nose and throat at the Bowman Gray School of Medicine, Winston-Salem, N. C.

Dr. J. Harold Medlin of Miami recently attended a course in surgical anatomy, operative surgery and clinical surgery at the Cook County Graduate School of Medicine, Chicago.

Dr. Edward R. Annis of Miami recently addressed members of the auxiliary of the Miami Junior Chamber of Commerce. He chose for his subject "Miami As a Medical Center."

Three members of the Association appeared on the program of the Neuropsychiatric Seminar which was held in Orangeburg, S. C., in September. Dr. James G. Lyerly of Jacksonville lectured on "Prefrontal Lobotomy." Dr. Edward H. Williams of Miami spoke on "Preventive Psychiatry," and Dr. Samuel G. Hibbs of Tampa chose "Psychopathic Personalities" as the subject of his discourse.

Medical Officers Returned

Dr. Charles A. Johnson, Jr., who entered military service on May 31, 1941, received his discharge on July 11, 1946. His address is 1002 South Ft. Harrison Street, Clearwater. He held the rank of Lieutenant (jg) in the Naval Reserve.

WANTED: Association with a busy practitioner, preferably in Tampa or Miami; possess license to practice medicine in Florida; qualified; references. Write 69-29, P. O. Box 1018, Jacksonville, Fla.

WANTED: General practitioner for Waldo, Fla.; population, 1,138; 4,000 to 5,000 persons in immediate vicinity; citizens desirous of aiding physician; twelve miles from hospital. Write B. A. Beville, Box 126, Waldo, Fla. Phone No. 4.

WANTED: Physician to locate in Newberry, Fla.; population 1,000; good agricultural section; annual income should be \$15,000. Please write L. W. Adams, Pharmacist at Newberry Pharmacy, Newberry, Fla.

FOR LEASE OR FOR SALE: Normandy Isle Clinic, 1108 Normandy Drive, Miami Beach; situated in the heart of the shopping center; ideal for two or more physicians. Early investigation advised.

Medical Licenses Granted

Dr. Frank D. Gray, secretary of the State Board of Medical Examiners, has reported that of the 197 applicants who took the examination of the Board, held June 26-28, 1949, in Jacksonville, 185 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 185 successful applicants follow:

- Armbruster, James W., Memphis, Tenn. (St. Louis 1943)
Asher, Leo A., Jr., Shaker Heights, Ohio (Chicago 1946)
Austin, Burton F., West Palm Beach (Alabama 1917)
Bagby, Richard A., Tampa (Virginia 1943)
Bailey, John H., Jr., Rochester, Minn. (Pennsylvania 1943)
Banks, Cullen W., II, (Col.), Orlando (Howard 1948)
Barancik, Henry, Chicago, Ill. (Northwestern 1914)
Barreras, Luis A., Tampa (Havana 1934)
Batsche, Joseph H., Melbourne (Cincinnati 1947)
Baumann, David P., Houston, Texas (Cincinnati 1945)
Beach, George P., Jacksonville (Texas 1942)
Bell, Arlis G., Wrightsville, Ga. (Georgia 1943)
Bishopric, George A., Spray, N. C. (Duke 1949)
Bolker, Abraham, Brooklyn, N. Y. (Long Island 1935)
Box, Louise A., Miami (Iowa 1943)
Boyce, John C., Fremont, Ohio (McGill 1924)
Boyd, Jack L., Whitmore Lake, Mich. (Loyola 1941)
Brody, Arnold J., Miami (Washington 1947)
Brody, David R., Youngstown, Ohio (St. Louis 1943)
Brown, Alfred G., Jr., Fairfield, Ala. (Georgia 1948)
Browning, Malissa D., Bradenton (Buffalo 1949)
Brumfield, Fred O., New Orleans, La. (Louisiana 1942)
Brunoehler, Carl J., La Porte, Ind. (Indiana 1948)
Bryant, Milton F., Jr., Ann Arbor, Mich. (Michigan 1948)
Byrne, James B., Scottsdale, Pa. (Temple 1947)
Campbell, Ewell F., Atlanta, Ga. (Emory 1949)
Capozzella, Henry F., Rogers Heights, Md. (Georgetown 1944)
Coberly, James, Atlanta, Ga. (Emory 1949)
Coffey, Michael J., Trenton, N. J. (Maryland 1947)
Cole, Richard K., Jr., Orlando (Vanderbilt 1948)
Corse, Herbert L., Jacksonville (Duke 1949)
Croom, William C., Jr., Jacksonville (Washington 1945)
Crosby, William R., St. Petersburg (Temple 1941)
Daffin, Sidney E., St. Andrew (Tennessee 1946)
DeVan, William T., Fort Knox, Ky. (Pennsylvania 1937)
DeWitt, Chester A., Silver Lake, Wis. (Michigan 1925)
Doff, Simon D., Ponte Vedra Beach (Long Island 1939)
Doll, Stanley G., Lancaster, Wis. (Med. Evang. 1948)
Donoghue, Francis E., Rochester, Minn. (Columbia 1940)
Dorman, Fred I., Jr., Atlanta, Ga. (Emory 1949)
Dowling, Judson D., Jr., Mount Olive, N. C. (Washington 1940)
Droege, Frederick D., Bay Pines (Cincinnati 1943)
Elkind, Maurice P., Brooklyn, N. Y. (Middlesex 1944)
Ellis, Robert S., Temple, Texas (Tulane 1944)
Eyles, James A., Miami (England 1929)
Fackler, William B., Jr., Chamblee, Ga. (Emory 1942)
Ferrer, Nicanor, Miami (Boston 1939)
Finch, Henry M., Atlanta, Ga. (Emory 1949)
Finch, Thomas V., Philadelphia, Pa. (Tulane 1940)
Fisher, Frederick W., Louisville, Ky. (Louisville 1949)
Fox, Sidney, Coral Gables (Scotland 1939)
Frank, Randolph A., Washington, D. C. (Vanderbilt 1948)
Frankel, Bertram J., Bridgeport, Conn. (Middlesex 1947)
Frell, Thomas C., Coral Gables (Ohio 1944)
Gage, George R., Coral Gables (Columbia 1942)
Gallo, William J., Miami Beach (Columbia 1933)
Garner, Joe F., Dothan, Ala. (Long Island 1945)
Gernon, William, Kankakee, Ill. (Illinois 1934)
Gilbert, Michael M., Los Angeles, Calif. (Michigan 1948)
Glass, Lamar F., Atlanta, Ga. (Emory 1949)
Godersky, George E., St. Petersburg (Indiana 1942)
Goss, Albert S., Jr., Atlanta, Ga. (Emory 1946)
Groskloss, Howard H., Miami (Yale 1935)
Gulotta, Carl J., New Orleans, La. (Tulane 1941)
Hammel, Joseph V., St. Petersburg (Buffalo 1943)
Harley, John F., South Miami (Ohio 1945)
Hartley, William C., San Antonio, Texas (Emory 1949)
Haynal, Andrew P., Orlando (Med. Evang. 1948)
Healy, Maurice J., Oakdale, La. (Iowa 1937)
Hicks, William M., Jr., Cincinnati, Ohio (Cincinnati 1948)
Holderman, Mary G., Philadelphia, Pa. (Women's Med. 1948)
Holzer, Oswald A., Chattanooga (Czechoslovakia 1937)
Hooten, Claude G., Jr., Dade City (Duke 1944)
Howard, Everett E., Mount Dora (Louisville 1913)
Hughes, Lawrence M., New Smyrna Beach (Indiana 1931)
Hughes, Warren M., Miami (Utah 1947)
Hyde, Robert T., Atlantic Beach (Johns Hopkins 1941)
Isaacs, Ivan, Brooklyn, N. Y. (Cornell 1939)
Jaffe, Morris, New York, N. Y. (Long Island 1917)
Jana, Joseph T., Jr., Coral Gables (Georgetown 1940)
John, Ellsworth H., Live Oak (Louisville 1935)
Johnson, James P., Jr., Lakeland (Duke 1948)
Jones, Gus W., Jr., El Dorado, Ark. (Arkansas 1939)
Katzman, Joseph D., Miami (Scotland 1940)
Kaufman, Harold S., Bronx, N. Y. (New York 1938)
Kelly, Walter C., Palatka (Temple 1949)
Ketchum, Clarence W., Valdosta, Ga. (Emory 1939)
Kinard, Conrad L., Atlanta, Ga. (Emory 1949)
King, Herbert A., Durham, N. C. (Duke 1943)
King, Taylor, Jacksonville (Vanderbilt 1948)
Kirkley, William H., Fitzgerald, Ga. (Emory 1946)
Kobley, Donald E., Miami Beach (Emory 1948)
Lane, John G., Jr., Jacksonville (Geo. Washington 1949)
Lawler, Harold T., Peoria, Ill. (St. Louis 1941)
Lawrence, Howard F., St. Petersburg (Bellevue 1904)
Leb, Samuel, Miami Beach (St. Louis 1949)
Lipton, Simon M., Miami Beach (Middlesex 1940)
Lohrbauer, Leif T., Grand Forks, N. D. (Marquette 1927)
Lyerly, James G., Jr., Jacksonville (Virginia 1949)
McCall, Joel V., Jr., Jennings (Temple 1944)
McEvoy, Joseph P., St. Paul, Minn. (Minnesota 1943)
McGee, William A., Richmond, Va. (Virginia 1924)
McRae, Duncan B., Jacksonville (Georgia 1942)
Madison, William M., Jr., Jacksonville (Emory 1949)
Martorell, Richard A., Tampa (Tennessee 1948)
Maxon, Robert von P., Mary Esther (Tulane 1948)
Meadows, Benjamin J., Jr., Ocala (Temple 1948)
Medoff, Lawrence R., Louisville, Ky. (Chicago 1939)
Miller, Saul, Miami Beach (Switzerland 1941)
Moorhead, Joseph H. (Col.), Fort Lauderdale (Meharry 1945)
Morris, Joseph H., Panama City (Tulane 1942)
Morse, Seymour, Winter Haven (Long Island 1942)
Moseley, Thaddeus M., III, Nashville, Tenn. (Vanderbilt 1943)
Mosig, John J., Belmar, N. J. (Hahnemann 1942)
Murphy, Douglas R., Jacksonville (Louisville 1944)
Myers, Rex E., Jr., Tampa (Temple 1948)
Nash, Selig R., Miami (Middlesex 1946)
Nixon, Donald H., Detroit, Mich. (Wayne 1948)
Nixon, James D., Panama City (Temple 1949)
Northup, Aldrich H., Pensacola (Duke 1949)
Novak, Louis J., Chapel Hill, N. C. (Boston 1945)
Odess, John S., Birmingham, Ala. (Vanderbilt 1946)
Ogden, Alfred E., Miami (Tennessee 1948)
O'Hara, Bernard F., Palm Beach (St. Louis 1949)
Pararo, Luther L., Jr., Crawfordville (Emory 1946)
Perez, Joseph, Brooklyn, N. Y. (Spain 1916)
Perry, Joseph Q., Pensacola (Louisville 1943)
Peschio, Daniel D., Buffalo, N. Y. (Buffalo 1935)
Phillips, Roger E., Orlando (Pennsylvania 1932)
Pilka, Herman J., Chicago, Ill. (Illinois 1923)
Plotkin, Paul, Miami Beach (Illinois 1944)
Plucinski, Stanley J., Miami Shores (Loyola 1920)
Poyner, James A., Panama City (Tulane 1947)
Puntereri, Anthony J., Lake City (Pittsburgh 1940)
Riesenbeck, Leo H., Miami (Cincinnati 1932)
Robbins, Jack H., Parkersburg, W. Va. (Med. Evang. 1948)
Roddenberry, Seaborn A., Jacksonville (Harvard 1942)

Rogero, Clarence R., Jr., Lantana (Temple 1945)
 Rogers, Ruth T., Daytona Beach (Rochester 1948)
 Rothrock, David R., Chattahoochee (Boston 1945)
 Rousch, Dwight I., Pinellas Park (Hahnemann 1915)
 Russell, Robert M., Monticello (Duke 1945)
 Russin, Lester A., Cincinnati, Ohio (Cincinnati 1936)
 Salvatore, Francis P., Jersey City, N. J. (Hahnemann 1948)
 San, James M., St. Petersburg (Duke 1944)
 Schneeberg, Arthur L., Philadelphia, Pa. (Hahnemann 1947)
 Schulz, Richard H., Winter Haven (Emory 1948)
 Schulz, Sarah M., Winter Haven (Emory 1949)
 Schwartz, Milton E., Brooklyn, N. Y. (Cincinnati Eclectic 1936)
 Seeley, Ellsworth C., Jacksonville (Louisville 1947)
 Sergis, Mooshy, Palm Beach (California 1939)
 Sexton, Carlton L., Annapolis, Md. (Vanderbilt 1948)
 Shannon, William A., Sarasota (Geo. Washington 1924)
 Shapiro, Richard D., Miami (Marquette 1941)
 Shirley, Calvin H., Fort Lauderdale (Boston 1947)
 Shroyer, Russell N., Miami (Indiana 1948)
 Siegel, Robert M., St. Petersburg (Emory 1949)
 Silvers, Louis D., Miami (Louisville 1946)
 Silverstein, Joseph, Chicago, Ill. (Rush 1936)
 Siragusa, James J., Jr., Boston, Mass. (Boston 1949)
 Smith, Warren S., Washington, D. C. (South Carolina 1946)
 Sornberger, Charles F., Boston, Mass. (Syracuse 1940)
 Speers, Dorothy J., Clearwater (Columbia 1949)
 Speers, James F., Clearwater (Columbia 1948)
 Stern, Bernard, Miami Beach (Louisville 1948)
 Stevens, Ernest J., Jackson, Miss. (Med. Evang. 1941)
 Strully, Leonard V., Paterson, N. J. (Long Island 1938)
 Styles, George W. (Col.), Miami (Meharry 1948)
 Thomas, Henry W., Dermott, Ark. (Arkansas 1939)
 Toto, Lawrence A., Bronx, N. Y. (Kansas City 1944)
 Townes, Andrew W., Nashville, Tenn. (Virginia 1948)
 Trygstad, Reidar, Long Island, N. Y. (Long Island 1928)
 Van Tilborg, Laurence D., Elkins Park, Pa. (Pennsylvania 1934)
 Vidal, Fred L., Gainesville (Tufts 1949)
 Voyles, Carl M., Jr., Vero Beach (Duke 1945)
 Weatherly, Carl H., Pensacola (Duke 1949)
 Weeks, Donald L., Jr., Richmond, Va. (Virginia 1949)
 Wells, Samuel M., Jacksonville (Harvard 1940)
 Wiener, Harvey, Brooklyn, N. Y. (Middlesex 1946)
 Wilkins, Charlotte K., North Miami (Ohio 1925)
 Williams, John S., Hopewell, Va. (1941)
 Wilson, Robert D., Tampa (Tennessee 1947)
 Witham, Abner C., Atlanta, Ga. (Johns Hopkins 1945)
 Wright, Irving S., New York, N. Y. (Cornell 1926)
 Wright, William L., Sarasota (Louisville 1936)

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Albee, Fred H., Jr., Orlando
 Beach, George P., Jacksonville
 Beebe, Milton O., Jr., St. Petersburg Beach
 Biddle, Percy D., Clearwater
 Murphy, Douglas R., Jacksonville
 Phillips, Roger E., Orlando
 Pilkington, Joseph W., St. Petersburg
 Williamson, Jos. P., Winter Park

COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Charlotte-Glades

At the September 13 meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, Dr. Elwyn Evans of Orlando was the guest speaker. He presented a paper on "Acute Benign Nonspecific Pericarditis."

Members attending the meeting were Drs. Harold S. Agnew, Roland W. Banks, Godfrey L. Beaumont, Henry P. Bevis, Isaac W. Chandler, Merle C. Kayton, Charles H. Kirkpatrick, Carl J. Larsen, Edwin C. Northup, Harold E. Parker, Wesley S. Pyatt, Zaven M. Seron, John A. Simmons, James G. Smith, Jr., and Howard V. Weems.

Marion

The regular monthly meetings of the Marion County Medical Society were resumed on September 21 at the "1890 House" in Ocala. During the months of July and August the members met jointly with the staff of the Munroe Memorial Hospital.

Dr. Eugene G. Peek, Sr., gave an interesting account of the activities and accomplishments of the Florida Medical Association Committee on Legislation and Public Policy, of which he is chairman.

Members attending the meeting were Drs. William H. Anderson, Jr., Matthew Arnow, Richard C. Cumming, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Eaton G. Lindner, John D. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles, Eugene G. Peek, Eugene G. Peek, Jr., Ralph E. Russell, Robert E. Thompson, Thos. H. Wallis and Harry F. Watt.

OBITUARIES

Ernest Thomas Kinsey

Dr. E. Thomas Kinsey of Madison died in a Miami hospital on July 25, 1949. He was 57 years of age.

Dr. Kinsey was born in Jefferson County in 1892. He received his medical degree at the Georgia College of Eclectic Medicine and Surgery in 1914, and was licensed to practice medicine in Florida the same year. He was a pioneer physician at Hollywood, beginning his practice there in 1924. Dr. Kinsey practiced medicine in Miami

(Continued on page 314)



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GYNECOLOGY—Intensive Course, Two Weeks, starting February 20. Vaginal Approach to Pelvic Surgery, One Week, starting November 7, March 6.

OBSTETRICS—Intensive Course, Two Weeks, starting November 7, March 6.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3.

MEDICINE—Intensive General Course, Two Weeks, starting April 3. Gastroscopy, Two Weeks, starting March 6.

DERMATOLOGY—Formal Course, Two Weeks, starting May 1. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic & Lecture Course first Monday of every month. Clinical Course third Monday of every month. X-Ray Therapy every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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from 1927 to 1941, when he retired because of ill health and made his home in Madison.

He was a member of the Madison County Medical Society, an honorary member of the Florida Medical Association, and a fellow of the American Medical Association.

Surviving are his widow, Mrs. Victoria Peppera Kinsey; two daughters, Amanda and Rose Marie, and also two daughters by a former marriage; two brothers, Evan Kinsey of Dania and J. W. Kinsey of Crestview; and three sisters, Mrs. J. E. Jenkins and Mrs. Arthur Cameron of Sanford, and Mrs. Carlton Dawkins of Jacksonville.

Raleigh Robert Sullivan

Dr. Raleigh R. Sullivan of Lakeland was found dead in his hotel room on Sept. 11, 1949. Death was attributed to a heart attack. He was 79 years of age.

Dr. Sullivan was born on Oct. 22, 1869, in Louisville, Ky. He was graduated from the University of Louisville School of Medicine in 1892 and had done graduate work at medical schools in Vienna, Austria. Following his graduation Dr. Sullivan began the practice of medicine in Beaumont, Texas. He moved his offices to Lakeland in 1911 and practiced there continuously until 1944, when he retired.

For many years he was a member of the surgical staff of the Morrell Hospital in Lakeland. He was a member of the Polk County Medical Society, and a life member of the Florida Medical Association and of the American Medical Association. Dr. Sullivan was a member of the First Methodist Church in Lakeland.


He is survived by a sister, Mrs. Lydia S. Browder of Lakeland, and by another sister who resides in Detroit, Mich.

Waldo Horton

Dr. Waldo Horton of Winter Haven was killed on Aug. 22, 1949, when his automobile collided with another car on the highway near Folkston, Ga. Dr. Horton's wife and her mother, returning with him to Winter Haven after their vacation in North Carolina, also were killed. He was 64 years of age.

Dr. Horton was born in Pennsylvania in 1885. He was graduated from Middlesex University School of Medicine at Waltham, Mass., in 1917.

(Continued on page 316)



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He began the practice of medicine in Massachusetts, but moved his offices to Winter Haven from Boston more than two decades ago.

The physician was active in the First Presbyterian Church, serving as an elder and a deacon and frequently teaching the men's Sunday School class. He was a member of the Winter Haven Masonic Lodge and a member of the Rotary Club. In the latter, he had a five year perfect attendance record and had served on several of its committees.

Dr. Horton was vice president of the Polk County Medical Society in 1946, a member of the Florida Medical Association, which he served as county chairman of the Committee on Medical Preparedness during the last war, and also a member of the American Medical Association.

Surviving Dr. and Mrs. Horton are two daughters, Mrs. James F. Carter of Hampton, Va., and Miss Anne Horton, who is a teacher at the Colegio Presbyteriano, Caibarien, Cuba.

Harold Franklin Preston

Dr. Harold F. Preston of Melrose died on Aug. 17, 1949 in the Riverside Hospital, Jacksonville, after an illness of ten weeks. He was 61 years of age.

Dr. Preston was born on Nov. 10, 1887 at Farmington, Ga., the son of William F. and Belle Durham Preston. He received his elementary education at Farmington and was graduated from the Georgia College of Eclectic Medicine and Surgery in Atlanta in 1915. Since January 1917, he had practiced medicine in Melrose.

Active for years in all worth while movements of his community and county, Dr. Preston served as a school trustee and in other posts of public welfare. Through the years he was a faithful member of the Melrose Baptist Church and of the Masonic Lodge.

Dr. Preston was a member of the Alachua County Medical Society and the Florida Medical Association, and was a fellow of the American Medical Association.

Survivors include the widow, Mrs. Susie Proctor Preston of Melrose; a son, Harold F. Preston, Jr., D.D.S., of Live Oak; two brothers, William O. Preston of Palatka and T. B. Preston of Pell City, Ala.; and one grandson.

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MRS. RICHARD F. STOVER, Romance of Medicine.....*Miami*

On Organization

As we approach the onset of our Organization Campaign, it is our earnest desire to enlist the membership and the aid of every doctor's wife in our state. Now, more than ever before, you are needed—when the very existence of your husband's noble profession is being threatened by forces in opposition to our American Way of Life.

We, as an Auxiliary, by united effort can achieve the goals set for us in all of our varied undertakings. We must be more completely organized to increase our effectiveness in the fields of legislation and public relations. This is a critical period, and we must reach every doctor's wife so that she in turn may reach the laity with our educational program.

A medical Auxiliary serves the medical profession and through it the public. Such service is satisfactory, because it is unselfish. Its principal functions are health education, public relations, legislation (reserve force), philanthropy and social activities. The laity requires education, but it should be given through the medical profession, so there may be rational control of what the public thinks and does in health activities. The most important objectives of an Auxiliary are to direct public thinking and actions in channels the medical profession desires, and to extend authentic information on health. We support an organization only when we are members and understand the tasks and objectives and how to accomplish them.

The busy wife is an asset to the Auxiliary, if she is an informed member, because she has many

(Continued on page 318)



From where I sit
by Joe Marsh

Now Hospitals Are "Banks," Too!

Doc Simpson was saying, "Hospitals are building up 'bone banks' that work just like blood banks. When bone is needed, the surgeon takes one from a refrigerator, cuts it to the right shape and simply splices it in."

"You doctors are sure making progress," I says, "but tell me, are any of the patients fussy about *whose* bone they're getting?"

"No sir!" replies Doc. "No more than they worry about *whose* blood they get. No one yet asked for a bone from a man who went to the same school or church he did."

From where I sit, it would be a better world if we were half as willing to accept other people's ideas and tastes, as we seem to be willing to accept their bone and blood. There'll always be differences. Some like buttermilk, others would rather have a sparkling glass of temperate beer. But underneath we're pretty much the same—deserving each other's respect and tolerance!

Joe Marsh

opportunities to carry the aims and decisions of the medical profession and keep health leadership where it belongs—with the profession. As a member, she may speak with authority, receive respect and attention that might not be given her as a non-member. It will not be necessary to partake of every phase of Auxiliary work to be a good member, only what one can do. She should know when to keep quiet, when to report to advisors, when to answer and what to say.

If for no reason but to assemble regularly and study the history of the medical arts and the medical heroes, an Auxiliary would be worth while, because it would give wives an understanding of the supreme unselfishness and the greatness of the profession.

The time has come when the Auxiliary has so proved its worth that the question is not, "Are you an Auxiliary member?" but, "Why are you not a member?" So may I urge that you enlist with us in this great cause?

Mrs. Chas. F. Henley, President



The Woman's Auxiliary of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society met on July 21, 1949, in the home of Mrs. Taylor W. Griffin of Quincy, with the Quincy members as hostesses. The president, Mrs. Merritt R. Clements of Tallahassee, presided.

Most interesting was the report of the educational committee on the work done to enlighten the public as to what socialized medicine would mean to them as individuals. The magazine, *Hygeia*, was reviewed by Mrs. Ernest W. Eker-meyer.

Guest speaker for the afternoon was Dr. Francis T. Holland who gave an interesting paper on "Socialized Medicine" with emphasis on the cost of the proposed program.

BOOKS RECEIVED

BLAKISTON'S NEW GOULD MEDICAL DICTIONARY. Editors: Harold Wellington Jones, M.D., Normand L. Hoerr, M.D., and Arthur Osol, Ph.D. Ed. 1. Price, \$8.50. Pp. 1294. Illus. 252. Philadelphia: The Blakiston Company, 1949.

This modern comprehensive dictionary of the terms used in all branches of medicine and allied sciences, including medical physics and chemistry, dentistry, pharmacy, nursing, veterinary medicine, zoology and botany, as well as medicolegal terms, is a completely new reference work. With the cooperation of an editorial board of eminent scholars and eighty other distinguished contributors, the editors have produced a welcome tool, attractive in arrangement, easy to read, and elaborately illustrated with 252 illustrations on 45 plates, 129 in color, including an anatomic section.

Every effort has been made to determine actual current usage and to record it with the utmost clarity and conciseness. Thousands of new entries reflect the most recent advances in all branches of medicine and allied sciences. Instead of being scattered throughout the book, tabular and statistical material has been segregated in a separate section. Pronunciation is shown by a new easy-to-use system of phonetic respelling with syllabification, and alternate pronunciations are given. First medical dictionary to be built on modern lexicographic methods, this outstanding contribution with its numerous helps and innovations for physician and student alike should be a timely and indispensable addition to every physician's library.



SHEARER'S MANUAL OF HUMAN DISSECTION. Edited by Charles E. Tobin, Ph.D. Ed. 2. Price, \$4.50. Pp. 286. Illus. 79. Philadelphia: The Blakiston Company, 1949.

In this revised manual or dissecting guide, designed to facilitate and enhance instruction in the gross anatomic laboratories, a compromise is achieved between the classical, lengthy manuals and the very brief guides for dissection for there is a workable balance between the amount of procedure for dissection and descriptive text. This manual is planned as an autonomous unit which need not be used in conjunction with, or with reference to, any specific descriptive text of human anatomy.

The dissection procedure for the entire body is presented; yet the dissected parts are kept in as near their normal relationships as possible so that relationships as well as individual parts can be studied. The plan of the manual can be adapted to any sequence of regional dissection. Featured are simplified text descriptions, additional illustrations and the new anatomic concepts developed since the first edition was published.

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Arthur C. DeGraff	New York	Heart
Maxwell Finland	Harvard Medical School	New antibiotics
Richard H. Freyberg	Cornell University	Compound E in arthritis
Chevalier L. Jackson	Philadelphia	Bronchoscopy
Herbert C. Maier	N. Y. Presbyterian Hospital	Chest Surgery
James F. Norton	Margaret Hague Maternity Hospital	Extra peritoneal caesarean section
Eugene P. Pendergrass	Pennsylvania Hospital	X-ray
E. R. Pund	University of Georgia	Smear diagnosis of cancer
R. L. Sanders	Baptist Memorial Hospital, Memphis	Biliary and peptic ulcer surgery
Albert M. Snell	Mayo Clinic	Medical treatment of gallbladder and liver
Walter G. Stuck	San Antonio, Nix Memorial Hospital	Backache
Donald H. Stubbs	Walter Reed Medical Center	Vascular and circulatory collapse
Oscar Swineford	University of Virginia	Allergy
Willard O. Thompson	Chicago	Misuse of estrogens — obesity
Richard W. TeLinde	Johns Hopkins Hospital	Cancer in situ (cervix)
Julius L. Wilson	Tulane University	Chest disease
Harold G. Wolff	Cornell University	Headache

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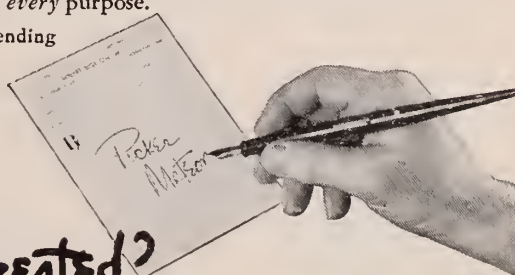


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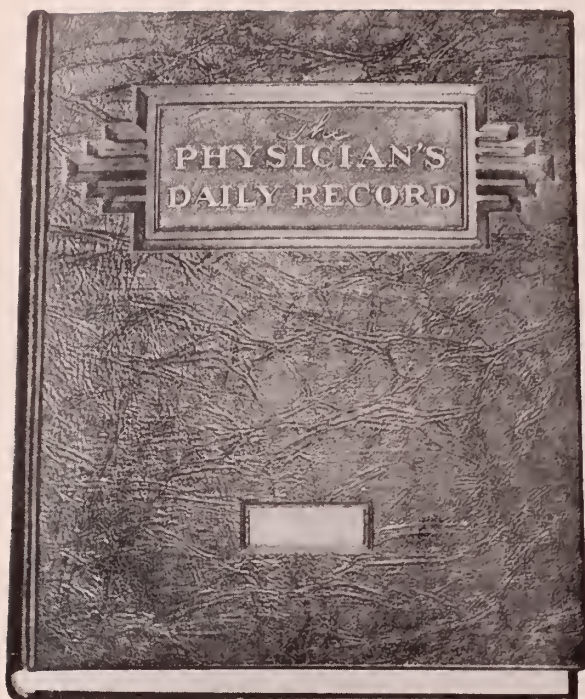
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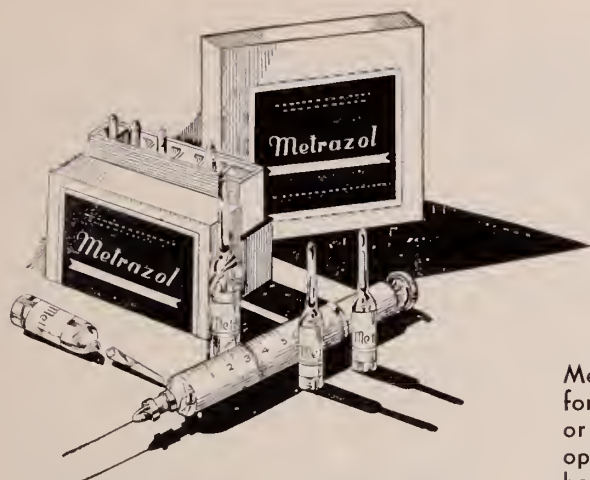


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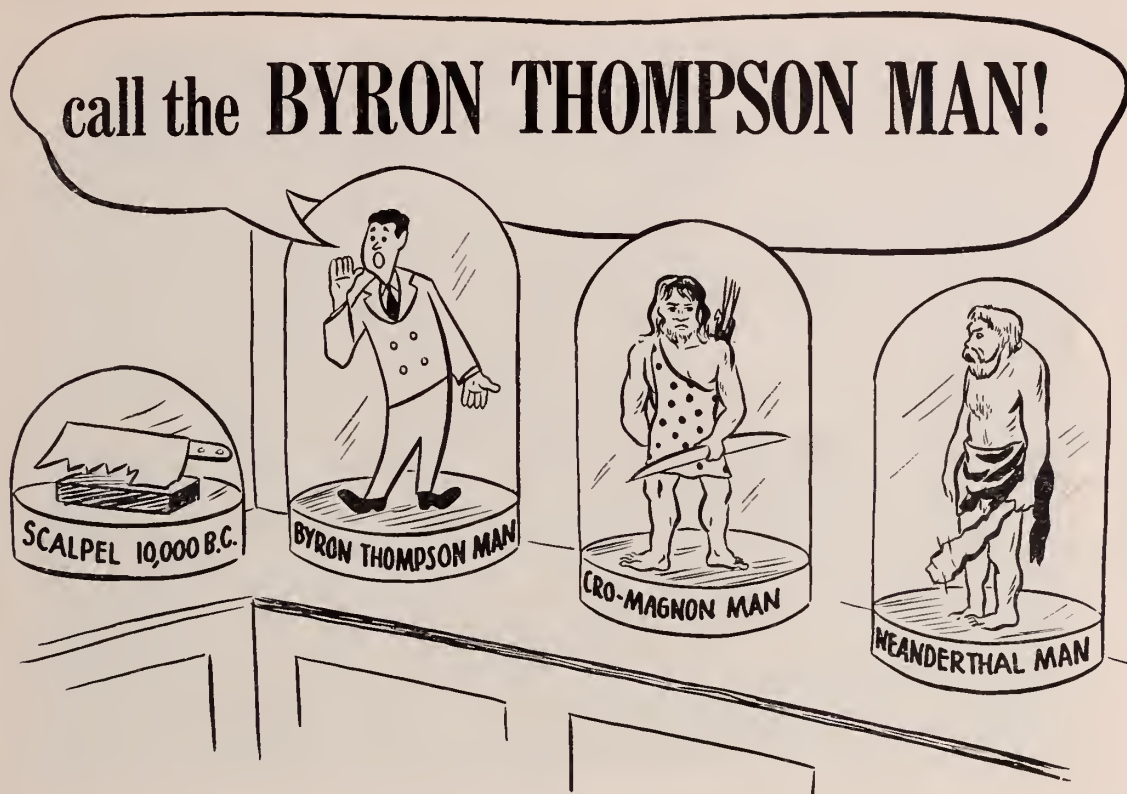
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Valter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochran, Daytona Beach	
C-Southwest	H. Quillion Jones, Ft. Myers	M. Crego Smith, Clearwater	
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	
Florida Specialty Societies			
Allergic Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Loenzo L. Parks, Jacksonville	" "
Heart Association	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Carolyn D. Braine, Orlando	" "
Ophthalm. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Edgar W. Stephens, Jr., W. P. Beach	Hugh A. Carithers, Jacksonville	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewit, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	W. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '49
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	Palm Beach, Nov. 10-12, '49
Hospital Association	Mr. H. Lonie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	Orlando, Nov. 28-29, '49
Hospital Service Corporation	Mr. W. F. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, Nov. 27-29, '49
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Mrs. Elsie M. Airheart, Tampa	Miss Helen Shearston, Miami	
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, April, 1950
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	Geo. W. Lull, Chicago	Washington, D. C., Dec. 6-9, '49
Southern Medical Association	Oscar B. Hunter, Washington, D. C.	C. P. Loran, Birmingham	Cincinnati, Nov. 14-17, '49
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Carnon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	St. Petersburg, April 5-7, '50
Southeastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., Feb. 11-12, '50
Southeastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5
Southeastern Surgical Congress	R. J. Wilkinson	B. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
Gulf Coast Clinical Society	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	

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				Total	Paid	
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Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Wewahatchka	3rd Tuesday Odd Months	7	100%	A-1-50 William P. Hixon, M.D. Pensacola
Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	17	
Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	14	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
Columbia Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
Leon-Gadsden Liberty-Wakulla Jefferson	McL. H. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	46	44	A-2-51 Taylor W. Griffin, M.D. Quincy
Suwannee	Joshua M. Price, M.D. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		6	100%	
Madison	A. Franklin Harrison, M.D. Madison	Merwin E. Buchwald, M.D. Box 214 Madison		4	100%	
Taylor *Dixie-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Trenton	Last Friday 8:00 P.M.	4	3	199
Alachua *Bradford-Gilchrist Union	Alva T. Cobb, Jr., M.D. 505 W. University Ave. Gainesville	F. Emory Bell, M.D. Box 400 Gainesville	2nd Tuesday 8:00 P.M.	40	100%	
Duval *Clay	Raymond R. Killinger, M.D. 225 W. Ashley St. Jacksonville	James G. Lescr, M.D. 1016 LaSalle St. Jacksonville	1st Tuesday 8:15 P.M.	255	237	
Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Betrana F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	30	28	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McCane, M.D. Fernandina	Last Friday 8:00 P.M.	2	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
St. Johns	Reddin Britt, M.D. Box 565 St. Augustine	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	3rd Tuesday 8:30 P.M.	15	14	B-3-50 Charles C. Grace, M.D. St. Augustine
Brevard	Charles E. Russell, M.D. Box 9 Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	14	100%	
Lake *Sumter	Leroy H. Oetjen, M.D. Leesburg	William L. Musser, M.D. Mount Dora	1st Wednesday 7:30 P.M.	20	100%	
Orange *Osceola	Robert P. Henderson, M.D. 544 N. Orange Ave Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	138	134	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
Seminole	Leonard I. Munson, M.D. Touchecon Bldg. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Joseph H. Rutter, M.D. Rt. 1, Box 303-A Daytona Beach	Robert L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	55	54	597
Hillsborough	William M. Rowlett, M.D. Box 786 Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	152	151	
Manatee	Willis W. Harris, M.D. First National Bank Bldg. Bradenton	Joseph A. Gibson, M.D. Palmetto	3rd Tuesday 7:00 P.M.	21	19	
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Sarasota	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	Fainedge S. Thompson, M.D. Box 224 Venice	2nd Tuesday 8:30 P.M.	27	25	
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Indian River	John P. Gifford, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
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St. Lucie Okeechobee Martin	Adrian M. Sample, M.D. Box 897 Ft. Pierce	Jerome A. Megna, M.D. 706 S. 6th St. Ft. Pierce	3rd Thursday 8:00 P.M.	12	11	
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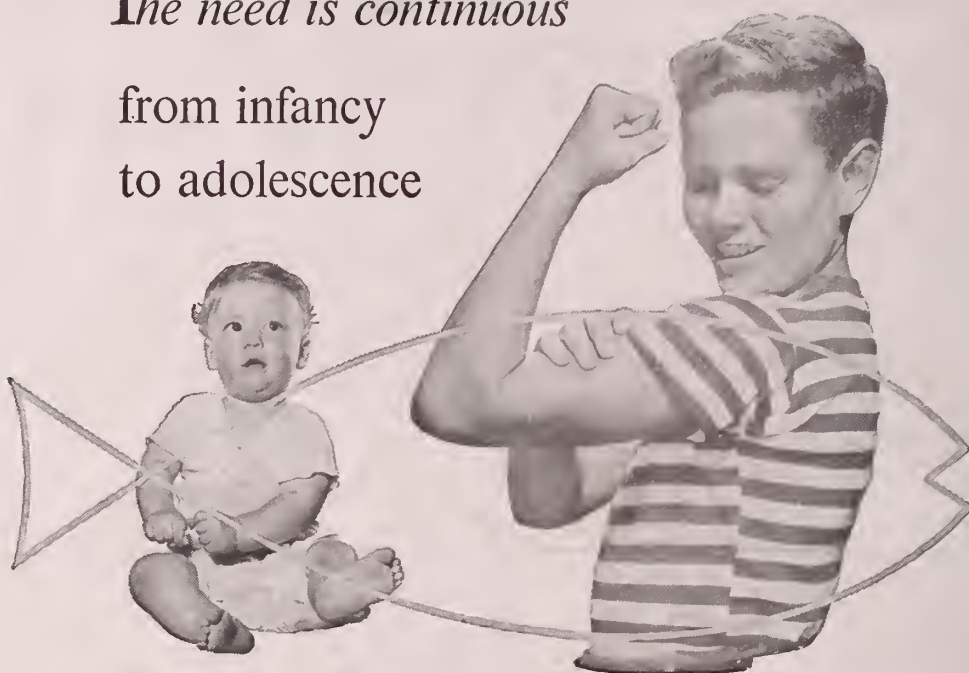
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

DECEMBER, 1949

No. 6

IN THIS ISSUE

Current Trends in Pediatrics
Warren W. Quillian, M.D.

Oliguria and Anuria
Arthur J. Butt, M.D.
Robert Birchall, M.D.

Sir William Osler
An Editorial

(Complete Table of Contents Page 336)



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*New and Nonofficial Remedies, Philadelphia,
J. B. Lippincott, 1949, p. 234.



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Volume XXXVI

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CONTENTS

SCIENTIFIC ARTICLES

Pediatrics: Current Trends in Practice and Training, Warren W. Quillian, M.D.	351
Streptomycin Therapy in Granuloma Inguinale, Roger F. Sondag, M.D., Jimmy F. Henry, M.D., and Joseph Batsche, M.D.	355
Prevention and Treatment of Oliguria and Anuria Due to Sulfonamides, Arthur J. Butt, M.D., and Robert Birchall, M.D.	360

ABSTRACTS OF MEDICAL ARTICLES

Dislocated Disc of the Lumbar Region, Statistical Analysis of Series of Cases, James G. Lyerly, M.D., and Vernon T. Grizzard, M.D.	366
--	-----

(Continued on page 359)

EDITORIALS

Sir William Osler	370
Peace of Mind	371
Dr. Elmer Lee Henderson Honored in London	371
American Dream or Nightmare?	371
For Better Community Health	372

COMMENTARIES

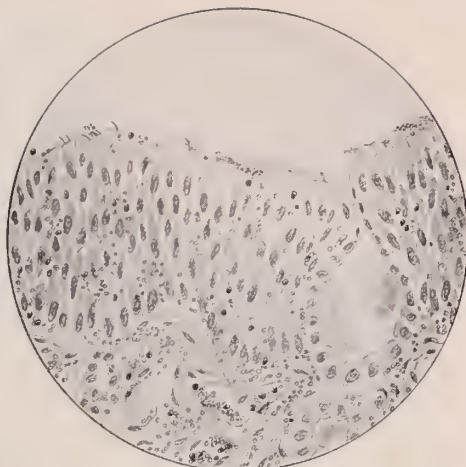
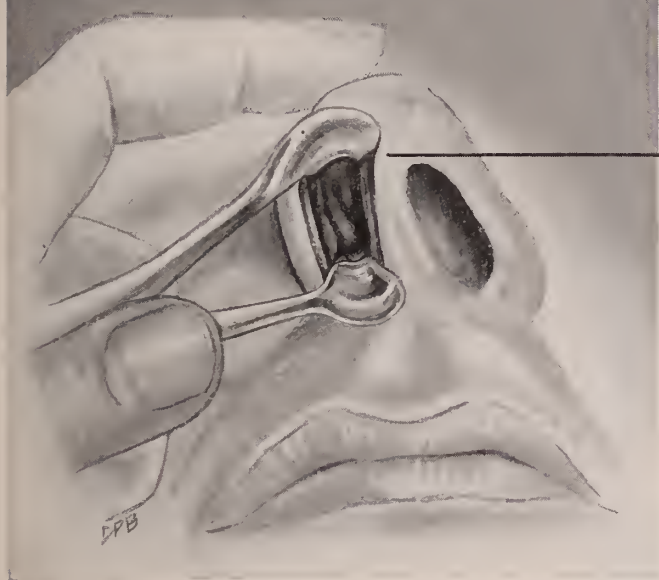
Medical District Meetings, 1949	372
---	-----

GENERAL FEATURES

Officers and Committees	368, 369
Your Blue Shield	375
State Board of Health	376
National Education Campaign	376
Births, Marriages and Deaths	377
State News Items	377
Medical Officers Returned	379
New Members	379
Component Society Notes	379
Obituaries	380
Woman's Auxiliary	384
Schedule of Meetings	389
List of County Medical Societies, Presidents and Secretaries	390

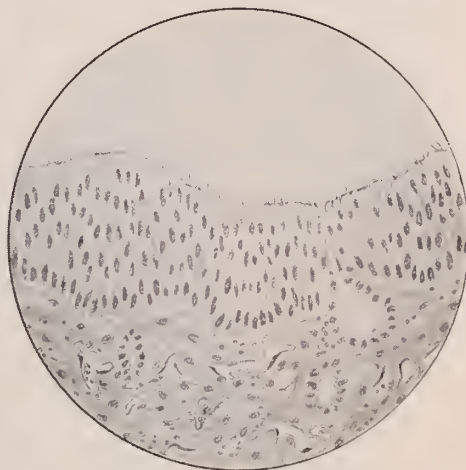
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References: 1. Dodd, K. and Minor, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minor, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

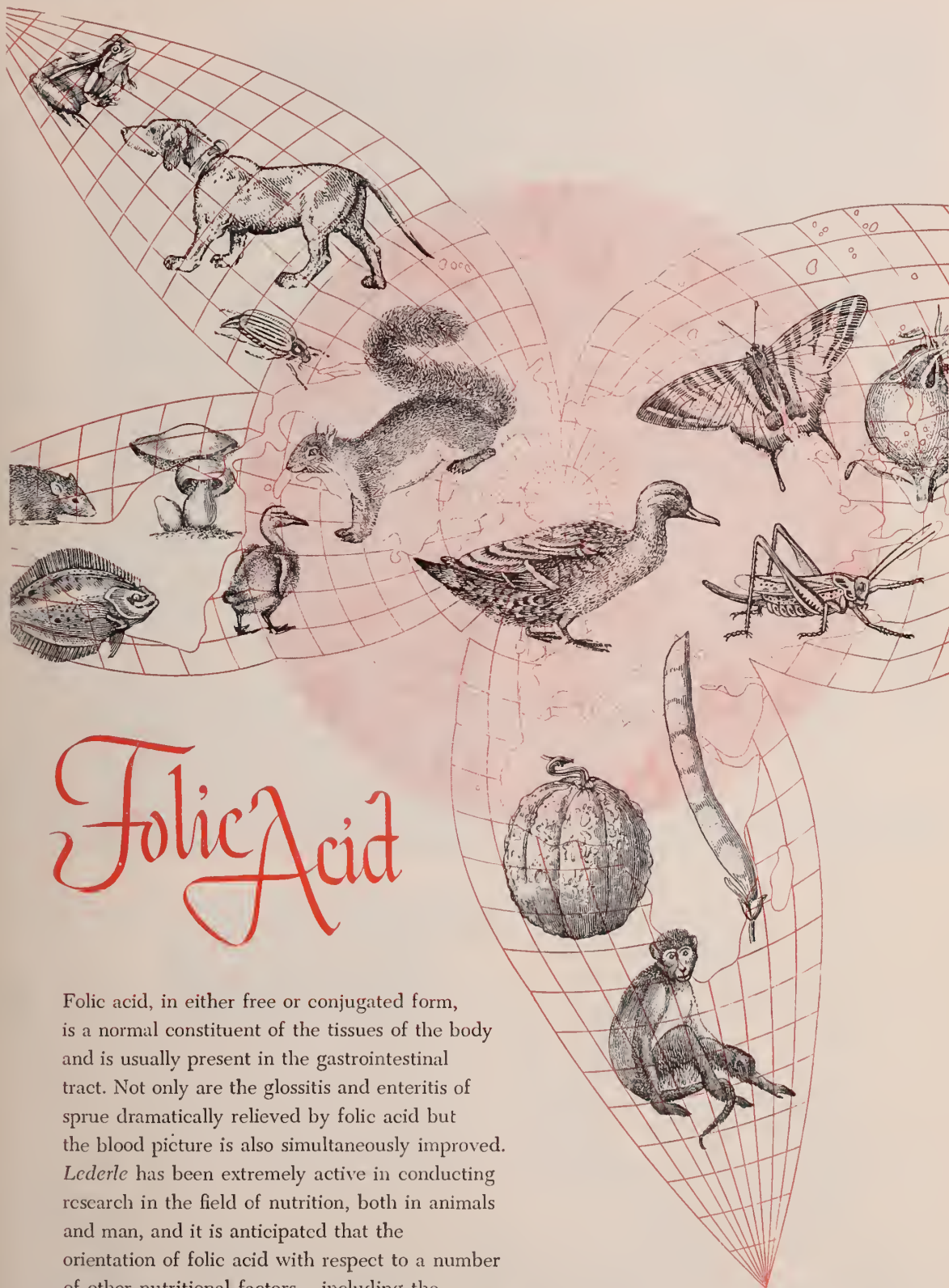
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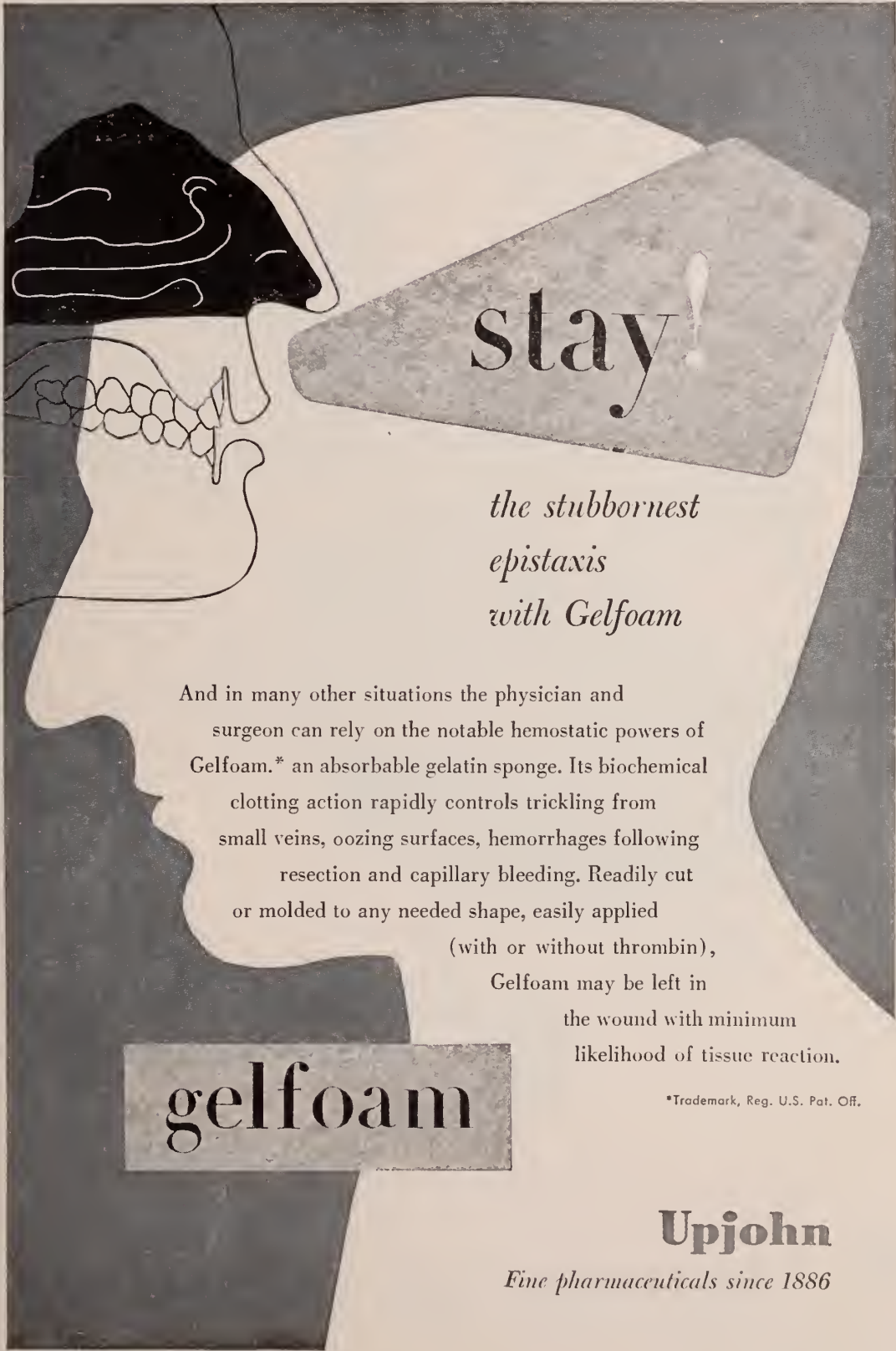


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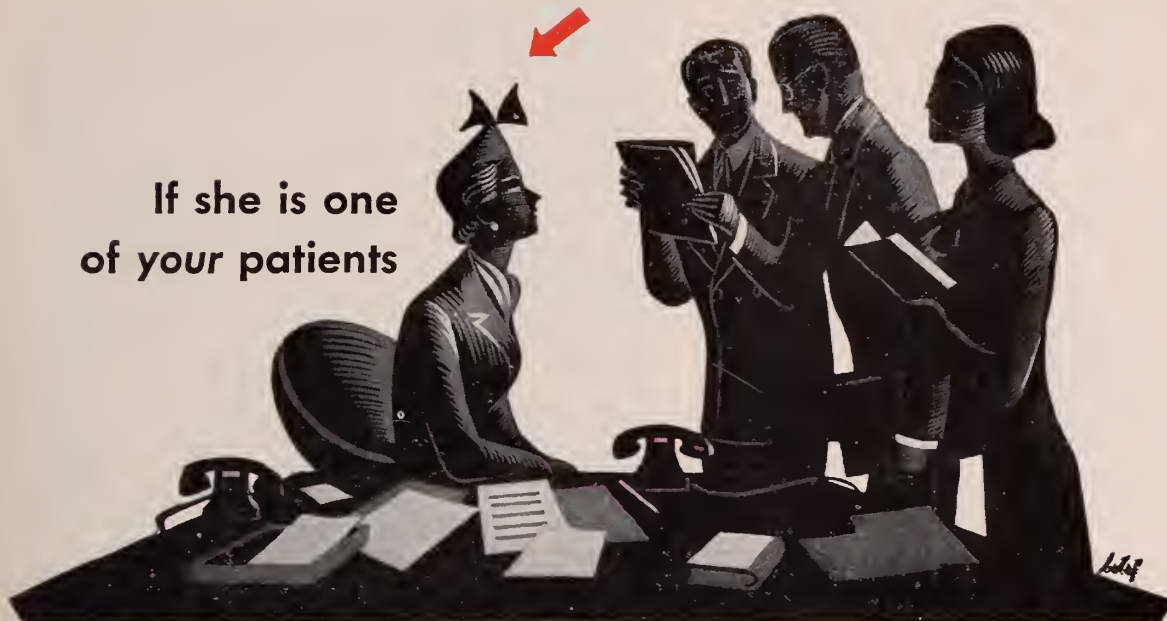
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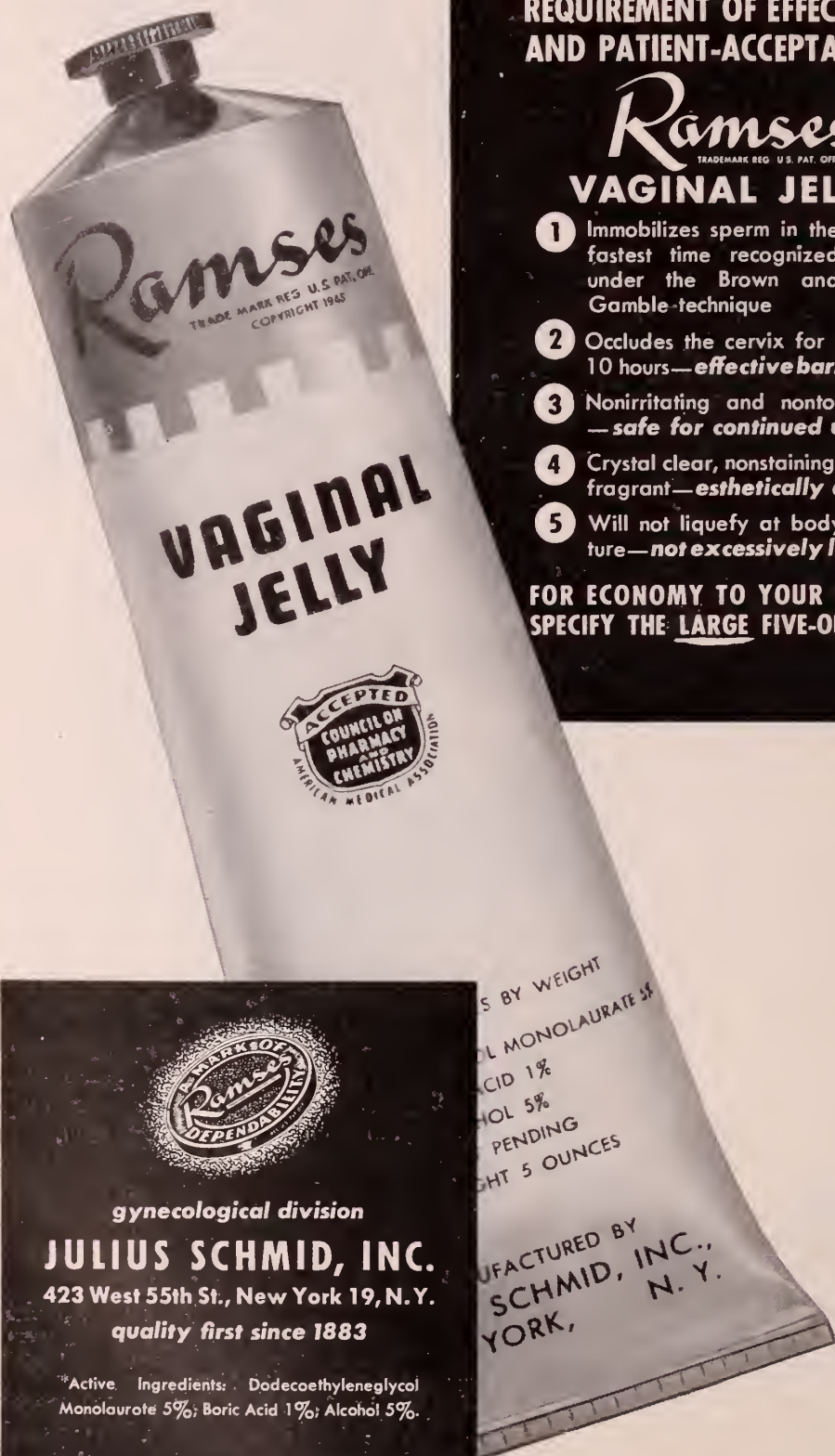


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Pediatrics: Current Trends in Practice and Training*

WARREN W. QUILLIAN, M.D.

CORAL GABLES

American medicine is being challenged as never before to assure that medical services of high quality are available to all citizens. There are about thirty-six million children in the United States under the age of 16 years, and another five million aged 16 and 17 years, altogether forty-one million, or nearly a third of the population. Each one of them needs help in his preparation for life; and each presents a challenge to all who are interested in his problems. Every year about two million babies are born in this country, so that about every eight seconds throughout the year a new life begins. The first twenty-four hours are the most crucial in the infant's entire life, since one third of the 111,000 infant deaths in 1946 occurred during this period. Almost three fourths of the first year's mortality occurs within the first month of life.¹ The health of adults depends greatly upon the medical attention which they receive in childhood. Hence, the problem of making good medical care available to all infants and children, no matter where they live or what their circumstances, is highly important.²

The Study of Child Health Services

Public interest in the improvement of child health is rapidly growing. To us, as physicians, it seems a reasonable assumption that better medical care for more children involves a modification of existing programs of medical education and the improvement of facilities for child care. The American Academy of Pediatrics, representing that branch of the medical profession specializing

in the care of children, is convinced that the doctors who give the care should undertake greater responsibility in planning for the improvement of child health.

In 1944, the first step was taken in an attempt to get the actual facts of existing conditions, by beginning a nationwide survey, which included four major fields of investigation: (1) general health services; (2) qualification, distribution and activities of professional personnel; (3) hospital facilities; and (4) pediatric education. Many surveys of child health have previously been made in local areas, dealing with limited aspects of the problem. But never before has there been a similar attempt to gather information pertaining to child health on such a wide scale at one time. One of the fundamental purposes of the study has been to stimulate local groups to evaluate services for child health in their own communities. This fact-finding study was completed in 1948; and there is a definite need for translating its findings into a program of constructive action.^{2b} It should be emphasized that the study could never have been accomplished by us as a group of physicians alone, nor by any existing governmental department alone. Physicians in private practice, those in academic and hospital administrative positions, dentists, and personnel from established governmental bureaus have worked effectively together in compiling the necessary data. The material represents the first comprehensive inventory and analysis of services of physicians and dentists in private practice, of hospitals and community health agencies both official and voluntary, and of pediatric education in medical schools ever undertaken in the United States.

*Based upon material derived from A Study of Child Health Services, American Academy of Pediatrics: (1) Health Service for Children in the United States; (2) Pediatric Education in the United States, July, 1948.

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 12, 1949.

Child Health Services

Certain general facts have crystallized from analysis of the survey:

1. There is great inequality, both in amount and type, of medical care received by children in different parts of the United States.

2. Children who live in or near large cities receive more and a better type of care than those who do not have access to urban centers.

3. The child who lives in a rural area is handicapped by a lack of clinical, specialist and hospital care, and does not have available highly skilled diagnostic and treatment services.

4. Existing community health facilities in these rural areas are inadequate to modify the type of school health services provided. These services are more abundant where more and better child care already exists.^{2b}

Pediatricians are, for the most part, available to children in or near large cities. Three quarters of the nation's practicing pediatricians are in cities of 50,000 or more population; one half are in the relatively few counties including and adjacent to greater metropolitan centers. But it is a fact that three fourths of the private care of children is in the hands of the general practitioner.³ It is evident then that better medical care for more children involves pediatric education for the general physician, as well as for the specialist.¹

Pediatric Education

Problems related to pediatric education warrant serious consideration. The survey shows that the present system of medical education is not well adapted to the training of physicians for general practice, one third of which is concerned with the care of children. Of the 70 approved medical schools which were studied, space was provided in the curriculum for an average of only 161 hours of clinical training in pediatrics. In one school, students are graduated after having received only 28 hours of actual contact with child patients. Modern emphasis upon proper growth and nutrition makes it inevitable that the pediatrician devote a great deal of his time to supervision of the well child. As yet, comparatively little attention is given, by formal exercises in the medical school or teaching hospital, to the preventive aspects of child care or to normal growth and development. Recently, a review of 1,000 consecutive case records during 1946 was made in my office to determine for what reasons average parents are now seeking help and advice from

the pediatrician. The results reveal a significant trend toward prevention, with early recognition and treatment of conditions which generally occur during the growth and development of the very young child constituting a large fraction of the practice.^{2c} This emphasizes a need for better preventive measures, since about half of the records examined represented the problems of sick children.

Medical Schools

There is little value in planning for more and better health services for children unless consideration is first given to providing well trained physicians to render those services. A crisis now confronts medical schools, as the result of inadequate financial support. Pediatric departments are especially handicapped. Half of the medical schools have pediatric budgets less than \$25,000; 21 departments have budgets less than \$10,000, and 11 less than \$5,000 annually.⁴ An editorial statement, which appeared in the *Journal of the American Medical Association* recently, is provocative of thought: "Unless there is general recognition of the need for more adequate support of medical schools, deterioration of the standards of medical education and medical research will ensue."⁵

In the Annual Report of the Council on Medical Education and Hospitals of the American Medical Association, the following statement appears: "The medical schools are almost unanimous in declaring that if they are to continue to meet the problems of inflation successfully and if they are to undertake new developments, important to their fundamental programs of undergraduate medical education, they will require additional operating funds in excess of those currently available. About four-fifths of the schools were able to furnish estimates of their needs. On the basis of the figures submitted, it can be estimated that the additional funds needed by all the medical schools amount to about 15 million dollars annually."⁶ It should be emphasized that this sum of 15 million dollars is stated as the annual requirement for operating expenses and does not include 200 million dollars estimated as required by 55 of the schools for capital improvements and development.

The cost of medical education to the student is such that he must often terminate his hospital service before he has had an opportunity to acquire special postgraduate training in the medical care and health of children. Consequently, an increased emphasis is being placed on the training

of general practitioners and on curricula arranged to provide training in pediatrics from patients rather than by didactic and other methods.⁷ Refresher courses for the family physician, and similar forms of intensive postgraduate training, should be organized in greater numbers.

It is impossible for clinical instructors, under the present setup in most medical schools, to teach pediatrics properly in the time allotted. A few schools have a maximum of 285 hours, which would represent 36 eight hour days. It would be impossible to learn the trade of a mechanic in that length of time. Medical students can become qualified physicians, competent to promote positive health in children and to offer them the best of medical care in sickness, if they first receive thorough training in the basic medical sciences and then gain clinical experience through supervised contact with patients. Gradual assumption of responsibility, with the application of fundamental principles to specific cases, is the foundation of good medical judgment.

Considerable emphasis has been placed in this discussion on present trends in medical education, because it is believed that the service rendered can be only so good as the training, skills and abilities of the physicians who give it. In the last analysis, good medical care for children depends not so much on the physical facilities of the hospitals, or the expansion of medical services, as upon the clinical judgment and skill of physicians. This skill can come only as the result of proper training and experience. Improvement in training is, therefore, the logical starting point in any program for the improvement of child health.⁴

Methods

Now that a need of better training for all doctors who provide child care and for a better distribution of services and facilities is apparent, what methods should be utilized to improve existing conditions? To facilitate better training, it must be made possible for physicians to acquire more hospital experience in child care through the strengthening of their undergraduate and graduate pediatric training. More clinical instruction is needed, which means a necessary reinforcement of teaching staffs. Graduate hospital work provides guidance and judgment in the application of theoretic learning to actual case problems. Financial aid in the form of fellowships is required for most young men in medicine who wish to round out their training as interns and hospital residents.

There is a definite need to provide more and

better medical care in the outlying areas where deficiencies have been found, and to make possible more pediatric training for general practitioners as well as specialists. As a means of fulfilling this need, it is proposed to extend to affiliated hospitals the pediatric education and services of nearby medical schools and teaching hospitals.⁴ The pediatric residents from the latter could, upon request from a qualified hospital in an outlying area, rotate through definite periods of service there. This plan would extend up-to-date methods and skills to the area concerned, and would enable the residents to observe pediatric practice away from medical centers, learning much through contact with general practitioners and their patients about the art of the practice of medicine. Small outlying hospitals, financially unable to maintain the services alone, would thus be able to establish contact with medical schools and teaching centers, to their mutual advantage. Decentralized graduate training, in this way and by means of local or regional intensive courses in postgraduate instruction, would provide a constant stimulus to the type of medical practice in the community concerned.

Specifically, then, it is appropriate to recommend constructive first steps in a program to improve the type of training and practice available to the children of Florida and of this country. These can be simply stated in four sentences:

1. Strengthen basic teaching budgets of the medical school pediatric departments for better preparation of medical students.
2. Extend medical teaching and services to outlying areas.
3. Provide fellowships for graduates who could not otherwise afford adequate training in pediatrics before entering actual practice.⁶
4. Coordinate decentralized medical education and services with action programs within the individual states.¹

An active publicity program is essential in order to keep constantly before the people the true interest of American physicians in their problems. The medical profession has not enjoyed good public relations during the past few years, and this situation is in part due to the loss of prestige by the doctor in his community contacts. There is lacking now the position of esteem formerly occupied by the family physician in the relationship between doctor and patient. In many instances, actual distrust exists. Education will overcome many misconceptions, and will overcome

much of the present antagonism toward us. The position of trust and respect formerly held by the old family physician should make us proud of our heritage, and stimulate us to renewed efforts in providing high standards of proficiency in the practice of the healing art. Good public relations can be most helpful when public support is needed against objectionable legislation, or in favor of legislation that organized medicine approves.

Standards of American medical practice are the highest in the world. The problem of improving deficiencies presently existing should be undertaken by the physicians themselves, and not by social reformers. If the medical profession believes that future progress in medicine depends upon the maintenance of free enterprise and the stimulation of individual initiative, it must accept the challenge presented by those who would regiment the profession, and who would impose upon the American people a system of compulsory sickness insurance. Physicians must spend more time in disseminating to the public actual facts concerning medical care and in cooperating with lay groups whose activities influence public opinion. Education concerning the value of voluntary prepayment medical care and hospital plans is important, depending upon local and individual needs. The Twelve Point Program, recently released by the Board of Trustees of the American Medical Association, is worthy of serious consideration and study. It represents a starting point for the advancement of medicine and the public health.

Retention of the American system of personal patient care and simultaneous development of some method to equalize the cost of unexpected and unavoidable, prolonged, exhausting illnesses present a major problem in our health program. The shortsighted view demands direct taxation to meet this need. But a safer method would seem to be expansion along present trends, with careful trial of hospital insurance, insurance covering physicians' services, and similar more conservative means of providing protection against unpredictable financial burdens. Several of these plans are already serving a good purpose and are expanding rapidly in effectiveness. Premature health legislation can serve no good purpose. Economic and social progress in the practice of medicine depends upon the sustained interest and effort of individual physicians. The influence and help of every doctor is needed in his home community for intelligent planning and progress. We cannot advance by further organization, administration, or regimentation. Since the logical leader and

guide in any effort designed for the improvement of present medical practice should be the physician, our responsibility as medical leaders is great. The American people are depending upon us not to shirk our task.^{2c}

Table 1.—Classification of 1,000 Consecutive Case Records (Office Practice)

Newborn	81
Well Child Conferences	325
Immunizations	104
Sick Children	475
Consultation Diagnosis (Problem Cases)	15

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Discussion

DR. COUNCIL C. RUDOLPH, St. Petersburg: Dr. Quillian has admirably covered a broad and intricate subject in the small time allotted to him.

It seems to me to boil down to the question of whether to educate more completely the general practitioner on pediatric problems or to train more physicians in pediatrics as a specialty. Certainly if the latter course is to be followed, there should be as well a greater education of the public regarding pediatrics as a specialty. There has been a great deal of progress in this respect in the past twenty-four years, the period during which I have followed pediatrics. At the time of my beginning, at least in St. Petersburg, the pediatrician was accepted more as a court of last resort than as a guiding hand for the rearing of normal children, and the idea of placing the infant under pediatric care at birth was considered a luxury and indulged in only by a relatively small percentage of the population. As a result, Drs. Martin and Cook in Tampa, Drs. Osincup and Sinclair in Orlando, Drs. Love and Holloway in Jacksonville, Drs. Quillian and McKibben and one or two others in Miami comprised the entire pediatric ensemble in the state. Truly the state has grown greatly in population during this period, but its growth in no way parallels that of the group of physicians over the state, now numbering fifty, who limit their practice to pediatrics. Today pediatricians are located in communities the size of Sarasota, Ft. Myers, Gainesville, Tallahassee and Clearwater, cities that twenty years ago would not have supported a pediatrician had they been double their present day size. All of these developments point to the fact that the public has become, one might say, more conditioned to pediatrics as a specialty. There is a great deal of room left, however, for improvement.

I think that one educational factor that has been overlooked is the education of the pediatric resident to the fact that a city of minimum population of 50,000 is not a requisite for his prosperity. Perhaps he will never accumulate a million dollars in a city of 20,000 to 25,000, but for that matter, show me one elsewhere who does.

Physicians in other specialties have found this out, I think, to a greater extent than those in pediatrics.

Regardless, however, of how many well trained pediatricians are available, a certain and large percentage of the infants and children will continue to be taken care of by the general practitioner, which is probably as it should be. It is especially important that he be equally as well trained to cope with pediatric problems, particularly those of nutrition and immunology, as he is to cope with those of geriatrics. This training again entails increased curricular time, which must be given at the expense of other departments or else, and God forbid, an increased total period of undergraduate and graduate instruction.

DR. WM. W. MCKIBBEN, Miami: On account of the premature and unexpected passing of our old friend, Dr. George L. Cook, to a higher plane recently, where he can practice pediatrics without pain or fatigue, Dr. Quillian permitted me to look over his pediatric paper on the study of child health services as embraced in the American Academy of Pediatrics' nationwide survey.

It would be presumptuous for me to discuss such a comprehensive paper. But I have long wanted this opportunity to acclaim publicly and voice the feelings of my fellow pediatricians, not only in South Florida, but throughout the whole state. They appreciate the time and money spent in putting the Southeastern part of the United States on the national map by Dr. Quillian appearing before such groups as the American Academy of Pediatrics, the American Medical Association, the Southern Medical Association and the Florida Medical Association.

Briefly, I want to refer to one point only. Dr. Quillian and I both have been brought up in small towns in Georgia and Arkansas where our kindly, honored, respected and even beloved family doctors were our best friends and advisers.

Dr. Quillian refers to the fact that the medical profession has not enjoyed good public esteem the past few years—at times has even been accorded distrust. I, too, only yesterday heard an attorney remark that the medical profession is today a commercialized profession.

The reasons seem plain enough when one considers the present day high cost of living for the struggling young doctor and his family. Suppose he does double his fee. His rent, his nurses' and technicians' salaries, and so forth, have quadrupled.

During World War II, two hundred old or partially incapacitated doctors were left behind in Dade County to do the work now done by nearly seven hundred efficient, young physicians, surgeons and capable specialists.

It is not a case of pup eat pup, but we might remember that the psychologist, William James, at Cambridge, quoted Tolstoi as dividing life into three parts, materialistic, humanitarian, and philosophic. Like the Kaiser and Hitler, the young business and professional men are after fame and fortune and "may the devil take the hindmost."

Thousands of these young doctors will soon be passing into the second, or altruistic, stage where they will be practicing the golden rule and will be instinctively establishing a much better relationship between doctor and patients.

Streptomycin Therapy in Granuloma Inguinale

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Granuloma inguinale, a serious, destructive, incapacitating illness, has been classified for many years as one of the minor venereal diseases. Proof that this disease is venereal in origin is far from convincing. Since, however, granuloma inguinale is, rightly or wrongly, generally considered among the group of venereal infections, it is minor only in incidence, being responsible for but 2.2 per cent of the total venereal disease reported in Florida during 1948 (table 1). Prevalence and incidence for the country as a whole have been estimated from 5,000 to 10,000 cases.^{1a,2,3}

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In Florida there has been an active program for the reporting and treatment of all venereal diseases. There has been an upward trend in the number of reported cases of granuloma inguinale (table 1). This does not necessarily mean an increase in incidence. Due to the highly developed interest in this disease since streptomycin has proved so effective, the increase in reported cases is attributed to better knowledge of the disease, better diagnostic procedures, better reporting of cases, and patient to patient advertising. The patient who has received beneficial results from streptomycin therapy invariably shares his good fortune with others in whom the disease is unrecognized and neglected and thus helps reduce the reservoir of unreported infections.

Table 2 shows the race and sex distribution of granuloma inguinale for the last five years. It is

Table 1.—Venereal Diseases Reported in Florida, 1944-1948, Inclusive

Year	Total Venereal Diseases		Syphilis		Gonorrhea		Chancroid		Granuloma Inguinale		Lymphopathia Venereum	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
1944	34,439	100.0	19,087	55.4	14,351	41.7	535	1.6	218	.6	248	.7
1945	35,799	100.0	16,546	46.2	18,088	50.5	722	2.0	246	.7	197	.6
1946	35,866	100.0	16,067	44.8	18,548	51.7	818	2.3	257	.7	176	.5
1947	38,045	100.0	16,653	43.8	20,160	53.0	745	1.9	271	.7	216	.6
1948	35,573	100.0	15,395	43.3	18,820	52.9	388	1.1	773	2.2	197	.5

Table 2.—Granuloma Inguinale Reported in Florida by Race and Sex, 1944-1948, Inclusive

Year	White				Negro				Total	
	Male		Female		Male		Female			
	Number	%	Number	%	Number	%	Number	%	Number	%
1944	8	3.7	8	3.7	106	48.6	96	44.0	218	100.0
1945	8	3.3	4	1.6	139	56.5	95	38.6	246	100.0
1946	8	3.1	3	1.1	123	47.9	123	47.9	257	100.0
1947	9	3.3	8	3.0	143	52.8	111	40.9	271	100.0
1948	8	1.0	4	.5	499	64.6	262	33.9	773	100.0

evident that this disease is far more prevalent among Negroes, the frequency suggesting a racial susceptibility. Since it is a disease of the poor and the unclean, it is occasionally diagnosed among white persons who are distinguished by miserable living conditions. From morbidity reports collected from state health departments, Clarke² reported the percentage of cases occurring in white persons varied between 8 and 12 per cent. From morbidity reports collected in Florida, the percentage of these cases varied from 7.4 per cent in 1944 to 1.5 per cent in 1948. Prior to 1948 the breakdown of tabulated cases by sex was comparable to statistics presented by Clarke,² indicating no significant difference between males and females. For 1948, however, the incidence was two times greater in males (table 2). The reporting of granuloma inguinale in 1948 almost tripled the report of any previous year, thus providing ample clinical material for the Rapid Treatment Center. This disease becomes so loathsome that few clinics and fewer physicians are willing to treat those afflicted with it. Because of the long incapacitating illness, the repellent appearance of the lesions, and the pervading odor surrounding the sufferers, there is hardly a refuge other than the Rapid Treatment Center.

Prior to the preliminary report of Greenblatt, Kupperman and Dienst^{1b} in April 1947 describing remarkable clinical improvement in lesions as a result of streptomycin therapy, the Rapid Treatment Center resorted to antimony compounds alone or in combination with escharotic agents. Soon thereafter a small supply of streptomycin was made available to the Rapid Treatment Cen-

ter by the United States Public Health Service. The initial results were excellent and essentially identical with those reported by Greenblatt, Kupperman and Dienst,^{1b} Hirsh and Taggart,⁴ Barton, Craig, Schwemlein and Bauer,⁵ and Marshak, Barton and Bauer.⁶

From September 1947 through Dec. 31, 1948, the Rapid Treatment Center treated with streptomycin a total of 597 patients with granuloma inguinale. This, therefore, is a report of what is believed to be the largest series of cases of granuloma inguinale analyzed up to the present time in which the patients were treated with this antibiotic. Of these, 378 (63.3 per cent) were males, and 219 (36.6 per cent) were females, all Negro patients except one white male. Table 3 lists the incidence by age groups. It should be noted that the greatest incidence occurs during the period of maximal sexual activity; in 403 cases (67.5 per cent) the ages ranged between 16 and 30 years. The one patient under 10 years of

Table 3.—Granuloma Inguinale Treated at Rapid Treatment Center, Incidence by Age Groups

Age	Patients
0-10	1
11-15	5
16-20	133
21-25	161
26-30	109
31-35	61
36-40	45
41-45	30
46-50	26
51+	26
Male	378
Female	219
Total	597*

* All Negro except one white male.

Table 4.—Percentage Distribution of Lesions According to Site

Site	Male	Female	Total
Extragenital	.5	.7	1.2
Scrotum	3.9	...	3.9
Fourchette	...	4.7	4.7
Vulva	...	8.1	8.1
Inguinal	8.1	2.0	10.1
Perianal	3.2	7.6	10.8
Labia	...	11.3	11.3
Penis, glans	13.0	...	13.0
Penis, foreskin	13.6	...	13.6
Penis, shaft	23.3	...	23.3
Total	65.6	34.4	100.0

age was a 7 year old Negro girl whose history indicated that she probably became infected through sharing a bed with her sister who was infected. From the history obtained from patients, the duration of the infection ranged from one week up to a period of twenty years.

Diagnosis

The lesion of granuloma inguinale is characteristically a destructive, shallow, dirty, irregular ulcer, with a granulating base. The lesions may vary in size from a diameter of 5 mm. to an extensive ulcer involving the entire saddle area from the pubis anteriorly to the presacral area posteriorly. In the small genital lesions satellite inguinal buboes may be present, but are rare; open ulcers in the inguinal region (pseudobuboes) are much commoner.

Table 4 shows the percentage location of lesions described in this series of 597 cases. The most frequent lesion was an ulcer of the shaft of the penis (23.3 per cent). This figure includes ulcers of the coronal sulcus, the most commonly involved site in the male. It will be noted that the percentage of inguinal lesions in the male was four times greater than for similar lesions in the female, and furthermore, that the percentage of perianal lesions in the female was two times greater than for similar lesions in the male. This selective involvement may well be explained on the basis of the different genital lymphatic drainage in the male and female, as is evident in the different effects lymphopathia venereum has in the two sexes. In this series, 78 per cent of the patients had single lesions and 22 per cent had multiple lesions. Only 1.2 per cent of the lesions were extragenital, the sites being the umbilicus, the interdigital spaces and the anterior aspects of the upper part of the thigh.

The lesions of granuloma inguinale give off a peculiarly pungent, fetid, foul odor which is almost diagnostic. Donovan body smears were

made of all lesions. Surface scrapings were stained with Wright's stain and examined for the presence of Donovan bodies, which were identified in 79 per cent of the cases. In the remaining 21 per cent, the diagnosis was established by clinical means, that is, appearance of the lesion, chronicity, odor, and exclusion of Ducrey and syphilitic infections. The diagnosis in these cases was also confirmed by the rapid response to streptomycin.

Method of Treatment

All the patients in this series received streptomycin. The first 470 patients were treated with streptomycin according to the schedule of Greenblatt, Kupperman and Dienst,^{1b} as follows: .66 Gm. of streptomycin diluted in 4 cc. of water, saline, or procaine solution given intramuscularly every four hours, or a total daily dose of 4 Gm. (schedule 1). Although the results with this schedule were satisfactory, it was believed that decreasing the daily dosage and spreading the total dosage over a longer period of time might tend to diminish the total amount of streptomycin required to effect healing. Consequently, the next 127 patients in this series were treated according to schedule 2, as follows: 0.5 Gm. of streptomycin in 5 cc. of diluent (water, saline or procaine solution) given intramuscularly every six hours, or a total daily dosage of 2 Gm. In both schedules the amount necessary to effect healing ranged from 5 Gm. to over 50 Gm. (table 5). 1 patient receiving a total of 70 Gm. With schedule 1 (470 patients) the lesions were healed in 43 per cent of the patients after 20 Gm. of streptomycin had been given; with schedule 2 (127 patients) in 40 per cent of the patients the lesions were healed after only 10 Gm. had been given. All patients were kept under treatment and observation at the Rapid Treatment Center until healing was complete or until it was thought that maximum benefits of treatment had been obtained.

Table 5.—Minimum Dosage of Streptomycin Required to Heal Lesions

Grams	Number of Cases
5	34
10	170
15	67
20	246
25	21
30	35
35	5
40	13
50	5
70	1
Total	597

Table 6.—Days of Treatment Required to Heal Lesions by Diagnosis

Number of Days	Granuloma Inguinale Alone	Granuloma Inguinale with Chancroid	Granuloma Inguinale with Lymphopathia Venereum	Granuloma Inguinale with Primary or Secondary Syphilis	Granuloma Inguinale with Two or More Venereal Diseases	Granuloma Inguinale with Latent Syphilis	Granuloma Inguinale with Congenital or Neurosyphilis	Total Cases
7	50	4	4	6		4		68
10	49	4	4	81	15	66	3	222
14	46	9	2	42	14	47	4	164
17	21	2	4	14	8	20	2	71
20	10			9	5		1	25
23	7		2	5	3	7		24
26	5			1	2	1	1	10
30	2					3		5
Over 30	4				2	1	1	8
Total	194	19	16	158	49	149	12	597

Once the diagnosis was established, an initial course of 5 Gm. of streptomycin was ordered. Subsequent treatment was ordered according to the response in each patient. Adjunctive therapy with penicillin, sulfonamides, or both, was required in approximately 80 per cent of the cases because of concurrent syphilis, lymphopathia venereum or secondary infection of the granulomatous lesion. Local therapy with potassium permanganate or potassium iodide soaks, urea crystals and tyrothricin was disappointing. The local application of sulfonamide powders, particularly in lesions involving apposing surfaces, seemed to speed healing.

Response to Treatment

In all cases there was a prompt, early response to streptomycin. Within the first twenty-four hours of therapy there was almost complete disappearance of the foul odor; pain, if present, was markedly diminished; the lesions tended to become dry and, in many, epithelization at the edges of the lesions was evident. Subsequent improvement was generally less rapid and was not uniform. The period of hospitalization ranged from five days to over ninety days; the average period was thirteen days (table 6). The variation and speed of response depended, in part, upon the presence of concomitant disease, including secondary infection and, to a lesser degree, upon the extent of the granulomatous lesions. Generally, the smaller lesions healed more rapidly. Paradoxically, however, one two-centimeter lesion of the glans penis required fifty-five days to heal.

Toxic Reactions

There were three reactions to streptomycin severe enough to cause the patient to complain to

the attending physician. One of these was an allergic reaction manifested by generalized urticaria which responded to antihistamine therapy and did not necessitate discontinuance of the streptomycin. In another case, there was a severe febrile reaction with meningism and mild delirium. This reaction occurred after approximately 1.5 Gm. of streptomycin had been given and disappeared within twelve hours after discontinuance of the drug. The third reaction was similar to those recorded by other investigators, consisting of vertigo, tinnitus and moderate deafness. These symptoms promptly disappeared with cessation of the drug.

Results

There were only 14 patients in whom the lesion failed to heal completely during their stay at the Rapid Treatment Center. Nine of these patients with persistent lesions were referred to cancer clinics, and on biopsy the lesions were found to be squamous cell carcinoma. Five of these have died. It should be emphasized that lesions of long duration which do not respond to streptomycin therapy should be subjected to biopsy to rule out carcinoma. This is now a routine procedure at the Rapid Treatment Center.

The tendency to relapse is a notorious feature of granuloma inguinale, and during this period of study, 28 patients were readmitted for additional treatment. An additional 178 patients (30 per cent) have been followed from three to sixteen months. Of this number, 164 patients (92 per cent) were completely free of open lesions at the time of the last follow-up examination. Since these patients were admitted to the Rapid Treatment

Center from every county in the state, it is obvious that follow-up of such a large series is not an easy task; however, it is believed that this group (35 per cent) represents a valid sample.

Summary and Conclusions

Five hundred and ninety-seven patients with granuloma inguinale were treated with streptomycin.

It was observed that streptomycin given at the rate of $\frac{1}{2}$ Gm. every six hours (2 Gm. daily) was more effective in the treatment of granuloma inguinale than 4 Gm. daily in regard to total dosage required to effect healing.

Thirty-five per cent of the patients in this series were followed from three to sixteen months. Twenty-eight patients were readmitted for additional streptomycin therapy. An additional 14 patients had open lesions at the time of last observation, necessitating readmission to the Rapid Treatment Center.

Of the number followed, 92 per cent of the patients were free of open lesions at the time of last observation.

With the exception of one white male, all patients in the entire series were Negroes.

Only 3 patients were observed with toxic reactions.

The total dosage of streptomycin varied from 5 to 70 Gm., and the average period of treatment was thirteen days.

Up to the present time streptomycin appears to be the drug of choice in the treatment of granuloma inguinale.*

Addendum

Since this paper was prepared, an additional 211 patients (of whom 47 were readmissions) have

been treated at the Rapid Treatment Center with 2 Gm. of streptomycin daily. Among the group of new admissions were 3 white patients. Four additional toxic reactions have been noted.

* The investigation of this series of cases was begun by Dr. John A. Barger, formerly Medical Officer in Charge of the Rapid Treatment Center.

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Box 210

Discussion

DR. WESLEY W. WILSON, Tampa: I wish to congratulate Dr. Sondag and his associates on their paper. My interest in this important crippling and disabling disease was first aroused ten years ago. About two years ago I was invited to report on a study of 63 patients with granuloma inguinale treated in Hillsborough County. At that time we had used only antimony therapy in the treatment of granuloma inguinale. Through Dr. Sondag's assistance, we obtained enough streptomycin to treat 2 patients who did not respond to other methods of treatment. The response was dramatic.

I have become greatly interested in this form of therapy. I did not realize there were so many patients in Florida with this disease. As Dr. Sondag pointed out, a larger number of patients has been treated up to the present in Florida than in any other one state in the country. It appears that with the advent of streptomycin those patients who were sent to the Rapid Treatment Center responded rapidly to treatment while previously they were often treated without good results. Dr. Sondag has also shown that some of the patients responded better with smaller doses of streptomycin given over a longer period of time. Previously, it was believed that the Donovan organism develops a tolerance for streptomycin rapidly, thus requiring the administration of the total dosage within four or five days.

ABSTRACTS OF MEDICAL ARTICLES

(Continue from page 336)

A Simultaneous Abdominal and Perineal Approach in Operations for Imperforate Anus with Atresia of the Rectum and Rectosigmoid, J. E. Rhoades, M.D., R. L. Pipes, M.D., and J. Perlingiero Randall, M.D.	366
Pediatrics, Changing Concepts and Responsibilities in Practice, Warren W. Quillian, M.D.	367
Pyribenzamine as an Adjunct in the Control of Morphine Withdrawal Syndrome, Paul Kells, M.D.	367
The Carotid Sinus Syndrome, Elwyn Evans, M.D.	367
Amyloidosis in Rheumatoid Arthritis, a Report of Ten Cases, Paul N. Unger, M.D., Morris Zuckerbrod, M.D., Gustav J. Beck, M.D., and J. Murray Steele, M.D.	368
Complete Dislocation of the Talus, Wendell J. Newcomb, M.D., and Ernest A. Bray, M.D.	368

Prevention and Treatment of Oliguria and Anuria Due to Sulfonamides

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AND

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NEW ORLEANS

The therapeutic value of the sulfonamides is universally acknowledged. Apparently it is less widely recognized that these drugs may adversely affect almost every system of the body, and that the most frequent site of involvement is the urinary tract. Since serious sulfonamide reactions are usually the result of indiscriminate and careless administration, their greatest danger lies in the physician's failure to assume responsibility for their correct administration as well as for the early recognition of untoward reactions. The magnitude of this problem is evidenced by the fact that 9 patients with anuria or oliguria following sulfonamide therapy have been treated by one of us (A. J. B.) in the past two years. In almost every instance this complication could have been prevented, since no attempt had been made to assure an adequate fluid intake, and not one of the patients had received concomitant alkali therapy. That 2 of these patients died as a result of injudicious administration attests to the potential seriousness of these reactions. The purpose of this paper is, therefore, to re-emphasize the importance of caution in the administration of sulfonamides, and to outline briefly those facts which pertain to the prevention and treatment of renal complications following sulfonamide therapy.

Causes of Renal Complications

Renal complications which may follow the administration of sulfonamides may be classified as due to:

- I. Mechanical Obstruction
 1. Extrarenal
 2. Intrarenal
- II. Nephrotoxic Reaction
 1. Simple degeneration of tubular epithelium
 2. Necrosis of tubular epithelium
 3. Glomerulitis

III. Combination of Mechanical Obstruction and Tubular Degeneration

I. Mechanical Obstruction

Obstruction of the urinary conduits, the most frequently encountered complication of sulfonamide therapy,¹⁻¹⁰ is due to the precipitation and impaction of concretions composed principally of the relatively insoluble acetyl derivatives. The factors which condition the formation of concretions are:

1. THE INDIVIDUAL SOLUBILITY OF THE VARIOUS SULFONAMIDES AND THEIR ACETYL DERIVATIVES. — Although solubility should not be the sole determining factor in selecting the sulfonamide to be employed, it should be considered carefully in planning a therapeutic regimen. Sulfanilamide,^{20-22a} sulfacetimide^{22b,23-26} and NU 445^{27,28} are almost completely soluble in any concentration obtained in the urine during therapy. The free and acetylated forms of sulfathiazole,^{12,21,29-31} sulfadiazine^{20,22a,c,d,31-33} and sulfamerazine³⁴⁻³⁸ are not entirely soluble in urine, although their solubility is greatly increased when the pH of the urine is raised above the critical value of 7.0. Lehr,^{22a} however, recently showed that when a mixture of two or more sulfonamides is present in the urine, the solubility of each component of the mixture is the same as if it were present alone, and Flippin and Reinhold³⁹ demonstrated the possibility of dissolving a considerable amount of sulfamerazine in a solution already saturated with sulfadiazine. Clinical application of this principle has shown that when a combination of sulfonamides is employed, the incidence of crystalluria is minimal, and the risk of obstruction is virtually eliminated.^{22c,e,f,g,39-40}

2. CONCENTRATION OF SULFONAMIDE IN THE URINE. — The plasma level of sulfonamide determines its concentration in glomerular filtrate; its ultimate concentration in the urine is determined by that facultative reabsorption of water which is

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a function of the distal convoluted tubules. It is, therefore, clear that since the solubility product of any sulfonamide cannot be exceeded until this segment of the nephron is reached, sedimentation and aggregation of suspended crystals will occur first in the collecting tubules. Tubular impaction may then occur in retrograde fashion,⁴¹ but, more commonly, further massing of crystals occurs distally in the calyces, pelvis, ureter, bladder and urethra. Stasis of urinary flow exaggerates the danger of crystallization.

3. THE pH OF THE URINE. — That the solubility of the majority of sulfonamides and their acetyl derivatives is greatly increased in alkaline solution is too well documented to require further discussion.^{31-33,39,42-44}

4. THE PRESENCE OF AN OBSTRUCTIVE OR INFLAMMATORY LESION IN THE URINARY TRACT. — Any pre-existing abnormality in the urinary conduits may furnish an all-important nidus for crystal growth, and be responsible for the initiation of crystallization from a supersaturated solution.⁴⁵

5. CRYSTAL AFFINITY. — The affinity of one crystal for another, a surface tension phenomenon, is directly responsible for the formation of the crystal aggregates which form concretions.⁴⁶

II. Nephrotoxic Reactions

Long, Haviland, Edwards and Bliss⁴⁷ early recognized that anuria following sulfonamide therapy might be due to true toxic injury, as well as to mechanical obstruction. It is now well established that, regardless of whether the changes are due to hypersensitivity or to a direct toxic effect of the drug, the pathologic entity responsible for this type of anuria is degeneration and necrosis of the epithelium of the distal convoluted and collecting tubules.^{3,22h,46-55} Glomerular changes are far less frequently described,^{45,48c-51,56} although the extreme hyperchloremia and hypernatremia reported by Luetscher and Blackman⁵³ and Murphy, Kuzma, Polley and Grill⁴⁹ suggest a specific tubular defect, complete inhibition of carbonic anhydrase, or a glomerular-tubular imbalance which would, a priori, imply a concomitant glomerular lesion.

Prevention and Treatment of Renal Complications

It is necessary to differentiate obstructive from nephrotoxic anuria because the methods used for their prevention and treatment are at variance. Differentiation is made by cystoscopic examination and ureteral catheterization. The presence of impacted crystals in the lower part of the uri-

nary tract indicates obstruction, whereas the absence of urine, or the finding of a small amount of urine free from crystals, indicates that the anuria is due to toxic nephrosis. The latter finding may rarely be occasioned by the intrarenal precipitation of sulfonamide crystals, but the treatment will, of necessity, be that of anuria due to toxic nephrosis. Since the methods of prevention and treatment of the two types of renal complications are unrelated, they will be outlined separately:

I. Anuria Due to Obstruction

A. PREVENTION is logically based on a consideration of those factors which condition the formation of concretions:

1. Renal function must be estimated before a plan of treatment can be outlined. The establishment of impaired renal function will immediately suggest a smaller dosage of sulfonamides, in order to prevent excessive plasma levels, and will induce caution in the administration of alkali. The danger of obstruction will be minimized, since the concentration of sulfonamide in the urine will approach its concentration in the plasma; however, the hazard, although not the incidence, of a nephrotoxic reaction will be increased.

2. The particular sulfonamide to be employed in any individual patient must be carefully selected. If the patient is cooperative and under constant surveillance, and if proper precautions are taken, little attention need be paid to the solubility constants of the various sulfonamides. In infants, in a dehydrated patient, or in patients in whom an adequate intake of fluid and alkali cannot be assured, reliance must be placed on the greater solubility of sulfanilamide, sulfacetimide and NU 445, or of a mixture of two or more sulfonamides. We recommend the use of sulfonamide mixtures, for sulfanilamide is less effective and less well tolerated than the newer derivatives; sulfacetimide produces inadequate plasma levels in the usual dosage, and NU 445 has been neither thoroughly evaluated nor demonstrated to be superior.

3. The concentration of sulfonamide in the urine should be kept within safe limits by maintaining the plasma level between 5 and 10 mg. per hundred cubic centimeters, and by assiduously avoiding dehydration. Except under unusual circumstances, a daily fluid intake of 3,500 cc. will assure a urinary output of 1,500 cc. in twenty-four hours, and will prevent a dangerously high concentration of sulfonamide in the urine. It is clear

that the patient's total intake and output must be measured and recorded every twenty-four hours. It should also be remembered that the process of crystallization may be extremely rapid; therefore slow, sustained diuresis, established and maintained by the frequent ingestion of small amounts of fluid, is superior to the alternating episodes of diuresis and antidiuresis that are induced by rapidly administered infusions, hypertonic solutions, or the ingestion of large amounts of fluid at widely spaced intervals.

4. With rare exceptions, the urine should be maintained at an alkaline pH. This is done by the addition of sodium bicarbonate or sodium or potassium citrate to the therapeutic regimen. The dosage will vary with the patient's surface area and renal function, and must be determined individually for each patient by testing the urine daily with nitrazene paper, and adjusting the dose until the urine constantly registers a pH of 7.5 or higher. Alkali therapy is not essential when sulfanilamide or sulfonamide mixtures are employed, but unless contraindicated, it is probably better to include it in the therapeutic regimen. In this connection it must be remembered that the pH of the urine is a specific function of the cells of the distal convoluted tubules. If renal function is sufficiently impaired, the pH of the urine will be unalterable, and the addition of large amounts of alkali will result in systemic alkalosis and further impairment of renal function.⁵⁷⁻⁶³

If the physician takes the precaution of assessing renal function prior to the institution of sulfonamide therapy, carefully selecting the most appropriate sulfonamide for that individual patient, and assuring adequate hydration and an alkaline urine, the possibility of inducing obstructive anuria is slight. The patient must, however, still be watched carefully for any untoward reaction. Crystalluria itself is not alarming, but the occurrence of hematuria, albuminuria, oliguria or renal and abdominal pain demands immediate withdrawal of the drug and institution of corrective measures.

B. TREATMENT.—A scout film of the urinary tract should be made in order to exclude obstructive calculi, although concretions of sulfonamides are not radiopaque unless calcareous material is superimposed. Cystoscopic examination and bilateral ureteral catheterization are then performed as emergency diagnostic and therapeutic procedures. If urinary suppression has been due to concretions, a copious gush of urine will escape

when the catheters are passed. The catheters are then secured in position and the renal pelvis lavaged with a warm 5 per cent solution of sodium bicarbonate. Once obstruction has been overcome, fluids can be liberally administered, and an attempt to alkalinize the urine, in order to increase the solubility of the concretions and increase the rate of sulfonamide excretion, seems justifiable.^{20, 34, 64, 65}

Since we are assuming that renal function is normal and that the obstruction has been removed, there is little to recommend the choice of one fluid over another. If the fluid is to be given parenterally, it is rarely necessary to give more than 1,000 cc. of saline solution in any twenty-four hour period; additional fluid can consist of a 5 per cent solution of glucose in distilled water. Isotonic solution of sodium sulfate may be used as an "osmotic diuretic" if desired, although its inclusion in the therapeutic regimen seems unnecessary. The amount of fluid required is simply that which will overcome any pre-existing dehydration, plus a sufficient excess to assure copious diuresis. It should be emphasized that if oliguria persists after normal hydration is re-established, it is due either to intrarenal precipitation of sulfonamide or to a combination of obstruction and distal tubular cell damage. To persist in "forcing fluids" under these circumstances is to court disaster; the patient is better treated as if the primary problem were acute toxic nephrosis.

II. Anuria Due to a Nephrotoxic Reaction

A. PREVENTION.—It is probable, although not certain, that nephrotoxic reactions are primarily the result of sensitivity to a particular sulfonamide derivative. The first step in its prevention, therefore, is the rigid exclusion from treatment of those patients who have shown previous episodes of sulfonamide idiosyncrasy or sensitivity. Each patient must be closely questioned about this before therapy is instituted. The only other approach to the prevention of nephrotoxic reactions is that suggested by Lehr,^{22d} who assumed that allergic reactions are at least in part dependent on the concentration of allergin, and that the mechanism responsible for the production of rash and fever is similar to that responsible for the cytotoxic reaction in the renal parenchyma. He offered evidence indicating that the incidence of drug rash and fever varies in direct proportion to the dosage of sulfonamide. It is insignificant at dosage levels below 2 Gm. and increases sharply

when the dosage is raised to 6 Gm. in twenty-four hours.

Since sensitization is restricted to the particular sulfonamide employed, the use of a mixture of sulfonamides in partial dosage should actually decrease the incidence of allergic reactions by "diluting" the concentration of the individual drug below that level necessary for the production of allergy. This author observed that with a dosage of 6 Gm. a day the incidence of allergic reactions among 61 patients treated with a mixture of sulfonamides was slightly less than 2 per cent, as compared with a reported incidence of 7.2 per cent for sulfanilamide, 11.2 per cent for sulfathiazole and 2.9 per cent for sulfadiazine. If both of these assumptions are confirmed in a statistically significant number of patients, the use of sulfonamide mixtures will represent an important contribution to the prevention of both types of complications in the treatment of disease of the urinary tract and will virtually replace the use of any one sulfonamide alone.

B. TREATMENT.—If oliguria or anuria develops, and ureteral catheterization fails to yield urine, or reveals a small amount of dilute urine high in chloride content but lacking in sulfonamide crystals, it can be assumed that the anuria is due to degeneration and necrosis of the epithelium of the distal and collecting tubules. In this situation, glomerular filtration is relatively unimpaired,⁶⁰ but the damaged epithelial cells coupled with the actual formation of tubulovenous shunts⁶⁷ offer little barrier to total reabsorption of all glomerular filtrate formed. Furthermore, it is clear that once anuria due to distal tubular cell necrosis has appeared, it will persist until regeneration of the necrotic tubular epithelium has occurred, and will be totally uninfluenced by overhydration, or by various diuretic agents. Treatment, therefore, resolves itself simply into maintaining the patient in as nearly normal fluid and electrolyte equilibrium as possible. Essentially this demands:

1. Restriction of total fluid intake to approximately 500 cc. a day.

This imposes a cruel curb on the physician's natural tendency to "force fluids" when faced with the problem of oliguria, but will be the measure for his success in the treatment of patients with acute toxic nephrosis. It has been thoroughly documented^{15, 67, 68a, 69, 70} that in the absence of fluid lost by vomiting, diarrhea or duodenal drainage, a total fluid intake of 500 cc. in twenty-four

hours, will, when supplemented by the water resulting from combustion and tissue breakdown, amply satisfy the body's needs. It can be given either intravenously or, preferably, by mouth, and may perhaps be best prescribed in the form of a low protein high carbohydrate beverage.⁷¹

2. Restriction of salt intake to 4 Gm. or less in twenty-four hours.

The need for additional salt is governed largely by the presence of vomiting, diarrhea or actual sweating. In their absence, electrolyte loss is minimal, and the addition of extra salt will favor hypertonicity of interstitial fluids and secondary cellular dehydration, as a result of evaporation of electrolyte-free water from the skin and lungs.⁷² The basic salt allowance should, therefore, be approximately 4 Gm. in twenty-four hours.^{69, 72} The amount of fluid lost as the result of vomiting or diarrhea must be carefully measured and replaced quantitatively with isotonic saline solution.

3. The ingestion or infusion of glucose should be relied upon to reduce protein breakdown, and inhibit the development of ketosis.⁷²

4. Alkali should be given only if there is both clinical and laboratory evidence of severe acidosis.^{68b} This can then be combated cautiously with intravenous injections of a solution of either sodium bicarbonate or sodium lactate.

5. Diuretics are contraindicated. This is particularly true of isotonic sodium sulfate, since the excess sodium ion will increase hydremia, vitiate everything accomplished by restriction of fluids and salt, and hasten the appearance of pulmonary edema.

If these basic measures, which are in direct opposition to those used in the treatment of obstructive anuria, are followed, the incidence of pulmonary edema will be decreased and the percentage of patients who recover proportionately increased. Regeneration of tubular epithelium, usually between the seventh and tenth days, will often be followed by profuse diuresis and rapid loss of electrolytes, for restoration of anatomic continuity should logically precede full restoration of function. It is, however, a simple matter to maintain a fluid intake equal to or slightly in excess of the urinary output, and to replace quantitatively the salt lost in the urine.

If, despite persistent application of these measures, the patient shows no evidence of recovery, and the situation appears desperate, recourse to some form of "artificial kidney" may become necessary. Although there have been many refine-

ments in technic since Abel, Rowntree and Turner⁷³ demonstrated the feasibility of reducing the blood urea of an animal by passing its blood through an apparatus consisting of cellulose tubing immersed in brine, the principle is simply that any substance which is filterable will dialyze across a semipermeable membrane to the extent that its concentration differs on each side of that membrane. In order to accomplish this, investigators have utilized the peritoneum,⁷³⁻⁸⁴ the mucosa of the stomach,⁸⁵ the small intestine^{86,87} and the large intestine,⁸⁸ and various synthetic membranes.⁸⁹⁻⁹⁴ Since these methods are still in the experimental stage and have not yet received widespread clinical use, a detailed description of each method is not warranted in this paper.

Summary and Conclusions

Renal complications of sulfonamide therapy are, to a large extent, preventable. They may be attributed primarily to indiscriminate administration of the drugs, the physician's failure to recognize untoward reactions, and the general public's ignorance of their potential dangers.

Oliguria and anuria are due either to mechanical obstruction or to destruction and necrosis of the epithelial cells of the distal convoluted tubules.

The importance of immediately separating the two types of anuria which result from administration of sulfonamides stems from the fact that methods for their prevention and treatment are entirely different.

Obstructive and nephrotoxic anuria can be differentiated by cystoscopy and ureteral catheterization. The demonstration of impacted crystals in the lower part of the urinary tract indicates obstruction; the absence of urine or the finding of a small amount of urine free from crystals indicates that the anuria is due to toxic nephrosis.

Prevention of obstructive anuria is based on the careful selection of the particular sulfonamide derivative employed, and on the maintenance of both an adequate intake of fluid and an alkaline urine.

Prevention of nephrotoxic reactions is based on the careful exclusion from sulfonamide therapy of all patients who have shown evidence of previous sulfonamide sensitivity. The value of sulfonamide mixtures in the prevention of nephrotoxic reactions has not yet been clinically established, although a promising line of investigation has been opened.

Treatment of obstructive anuria consists of the

dislodgement of the impacted crystals by ureteral catheterization followed by efforts designed to establish and maintain a rapid flow of dilute alkaline urine.

Treatment of anuria due to acute toxic nephrosis consists primarily of the rigid restriction of the basal fluid intake to 500 cc. in twenty-four hours, and of the salt intake to 4 Gm. in twenty-four hours. The amount of vomitus, diarrhea and duodenal drainage must be carefully measured and replaced with an equal amount of isotonic sodium chloride solution. The caloric intake is restricted to carbohydrate in an attempt to decrease protein breakdown and inhibit the development of ketosis.

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1101 North Palafox Street, Pensacola.

ABSTRACTS OF MEDICAL ARTICLES

DISLOCATED DISC OF THE LUMBAR REGION, STATISTICAL ANALYSIS OF SERIES OF CASES. By James G. Lyerly, M.D., and Vernon T. Grizzard, M.D. *South. Surgeon* 14: 755-765 (Nov.) 1948.

A study was made of 122 cases in which operation was performed for dislocated disk in the lower lumbar region. Statistical analysis showed that 68 per cent of the patients were men and 32 per cent women; in regard to age, the greatest frequency occurred in the fourth and fifth decades, 36.9 and 30.3 per cent respectively; low back pain, the first symptom of a dislocated disk, was present in 93 per cent, and pain in the leg or sciatica was present in 100 per cent. Clinical, laboratory, roentgen and operative findings are described.

The authors stress the diagnostic importance of the history, symptoms, findings and laboratory examinations; also, they emphasize that differentiation between subjective and objective symptoms and findings is important in the diagnosis of any lesion of the nervous system. The chief value of roentgen examination, including occasionally a pantopaque spinogram, lies in eliminating other diseases or injuries involving the spine.

The presence of multiple lesions in 25 per cent of the cases in this series makes obvious the importance of exploring two or more disks at every operation. Tumor of the cauda equina, present in 1.6 per cent of the cases, should always be considered in differential diagnosis. A spinal fusion is seldom required in conjunction with the operation for dislocated disk. In many cases of spondy-

lolithesis with signs of a dislocated disk, the symptoms of the latter may be relieved by the disk operation. If the patient is a heavy worker, the greater will be the need for a spinal fusion.

Most of the patients reported great improvement or cure, and approximately 9 out of 10 were working. Nearly three-fourths however, complained of occasional pain in the back and leg from one to two years after the operation.



A SIMULTANEOUS ABDOMINAL AND PERINEAL APPROACH IN OPERATIONS FOR IMPERFORATE ANUS WITH ATRESIA OF THE RECTUM AND RECTOSIGMOID. By J. E. Rhoads, M.D., R. L. Pipes, M.D., and J. Perlingiero Randall, M.D. *Ann. Surg.* 127:552-556 (March) 1948.

A one stage abdominoperineal operation is suggested for certain cases of imperforate anus in which the colon cannot be reached safely from the perineum. To facilitate this operation, the skin of the entire baby from the axillas to the toes is prepared so that the two approaches can be used simultaneously.

The authors report 2 cases in which they carried out this procedure in patients in whom the sigmoid, as outlined by roentgen ray, stopped at a point about halfway between the anal dimple and the umbilicus. They concluded that the simultaneous approach has advantages which help to make the one stage operation feasible.

PEDIATRICS, CHANGING CONCEPTS AND RESPONSIBILITIES IN PRACTICE. By Warren W. Quillian, M.D. South. M. J. 41:793-798 (Sept.) 1948.

Dr. Quillian emphasizes the purpose and functions of pediatrics as a profession, mentions current changes and trends, and suggests certain ways in which the pediatrician can more adequately measure up to his broad responsibilities. The scope of pediatric service, confined principally in the past to correction of recognized defects, prevention of infection and treatment of disease, has been expanded to include appraisal of proper growth and development, making supervision of the well child an important part of pediatric practice. Analysis of a thousand consecutive office case records in his practice revealed a significant trend toward prevention, with early recognition and treatment of conditions which generally occur during growth and development of the very young child, and it emphasized the need for better preventive measures in pediatrics.

Changing concepts are discussed from the standpoint of increasing public interest in the improvement of child health, reflected in the nationwide survey made by the American Academy of Pediatrics; the effect of war on child health, as reflected in a significant increase in functional problems and in deviations from the normal due, presumably, to stress; the function and privilege of the capable pediatrician to interpret and guide in home training; intelligent understanding of the influence of environmental factors and of emotional adjustment as a necessary reinforcement to the best programs of nutritional care and physical hygiene; and the challenge of behavior and maladjustment problems.

Under new responsibilities in pediatric practice are included the role of counselor regarding school placement, recreation, correction of faulty environment, and proper standards of entertainment including radio and motion pictures. Good pediatric practice includes an awareness of an atmosphere of friction and tension in the home as a possible clue to certain functional disturbances and problems of behavior in the child; the role of emotional stress in predisposition to disease merits careful study. The modern pediatrician has responsibilities to the community, too, including leadership in widespread movements that deal with measures for the betterment of children. The logical leader and guide in any effort toward improvement should be the physician, Dr. Quillian concludes; his responsibility as a medical leader is great.

PYRIBENZAMINE AS AN ADJUNCT IN THE CONTROL OF MORPHINE WITHDRAWAL SYNDROME. By Paul Kells, M.D. South, M. J. 41:134-139 (Feb.) 1948.

Defining a person addicted to morphine as one who has acquired a tolerance to this drug, the author postulates the formation of a chemical substance which comes to exist either in the body fluids or body cells in response to ingestion of morphine. He proposes this antimorphine substance elaborated by the body during morphine addiction as the factor responsible for the symptoms of the morphine abstinence syndrome.

It is concluded that pyribenzamine neutralizes this substance chemically and thereby alleviates the discomfort of the abstinence syndrome. Three cases are reported which illustrate the effectiveness of the pyribenzamine method of treatment. Dr. Kells warns, however, that the use of pyribenzamine is but one part of the total therapeutic procedure and that this drug is in no sense a morphine substitute.

THE CAROTID SINUS SYNDROME. By Elwyn Evans, M.D. Geriatrics 4: 90-100 (March-April) 1949.

Ten cases are reported in which the patients had probable carotid sinus syncope. All had spontaneous spells of unconsciousness, and similar spells were reproduced in each by carotid sinus pressure. No other cause for the attacks could be found.

The author observed that the carotid sinus syndrome is primarily a disease of men in the upper age brackets and that fatigue and emotional states, important in the vagal as well as the cerebral type, may account, at least in part, for spontaneous variations in carotid sinus sensitivity. He noted that other cardiovascular diseases are usually present and that psychotherapy is an important part of management. Pathologic changes in the wall of the sinus itself, he concluded, probably play a part in the picture, and associated abnormalities, such as Ménière's disease and the neurovascular syndrome in this series, may make the diagnosis appear more difficult or more serious. Other conclusions were that quinidine may reduce the number of seizures when ectopic beats are bothersome and that more than one type of carotid sinus syncope may not only coexist, but one form may predominate at one time and another at another time.

AMYLOIDOSIS IN RHEUMATOID ARTHRITIS, A REPORT OF TEN CASES. By Paul N. Unger, M.D., Morris Zuckerbrod, M.D., Gustav J. Beck, M.D., and J. Murray Steele, M.D. *Am. J. M. Sc.* 216: 51-56 (July) 1948.

In a study of 58 cases of rheumatoid arthritis in which autopsy was performed, these authors in seeking to determine the incidence of amyloidosis noted 4 cases in which amyloidosis could not be attributed to causes other than rheumatoid arthritis. In view of this finding, they made a search for amyloidosis in 56 cases of severe rheumatoid arthritis in which the patient was living. In 5 of 6 cases in which it was noted, it appeared certain that it was secondary to the arthritis; in the sixth case, one of tuberculosis arrested for eight years, the clinical findings attributable to the amyloidosis appeared sometime after the tuberculosis had become arrested and at a time when the rheumatoid arthritis was progressing rapidly.

A finding of great interest was the definitely low serum amino acid levels in all cases in which the patient was living. Hematologically, in all cases moderately severe normocytic hypochromic anemia was present, and in 4 of these 6 cases there was evidence of rheumatic cardiac involvement. As a part of a study directed toward improving the accuracy of the congo red test for diagnosis of amyloid disease, plasma volumes were studied in 5 cases, using T-1824 (Evans blue), and the volumes obtained were much greater than those predicted on the basis of body surface area. This finding was attributed to fixation of this dye by amyloid tissue giving erroneously high plasma volumes.

The authors concluded that the incidence of amyloidosis appears to be higher in rheumatoid arthritis than is generally believed.

COMPLETE DISLOCATION OF THE TALUS. By Wendell J. Newcomb, M.D., and Ernest A. Bray, M.D. *J. Bone & Joint Surg.* 30-A:872-874 (Oct.) 1948.

A case of complete dislocation of the talus is reported because of its rarity and because it demonstrates the need for immediate reduction, the possibility of revascularization, and the policy of preserving the talus. The advantages of reduction over astraglectomy are discussed, and five illustrations are presented.

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Sir William Osler

Many and many a physician today owes a debt to Sir William Osler which he can never repay. During those early days at the Hopkins and then at Oxford, mere contact with the master brought forth in men the spark and the glow of his spirit. They in turn passed that spark, that gift and heritage, on to countless numbers of others.

A smile at the bedside, a frolic in the nursery, a friendly nudge on the street corner, a practical joke in the home, a word of advice in the diagnostic clinic, a reference to a classic at a medical meeting never were forgotten, for they were part of the man—a man whose mind was prodigious, whose personality was disarming, and whose enthusiasm was never ending.

Many a bibliophile and not a few medical historians can trace their stimulus and the beginning of their interest to a few words which stemmed from William Osler. The stories and reminiscences about this lovable character, told by his students, colleagues and friends, are legion.

Dr. Thomas R. Brown, writing in 1920, had this to say about his former professor:

Everyone who has ever been his student is, as it were, still studying with him, or . . . following his footsteps as he journeys through life, always teaching some new lesson of medicine or of living. Every honor that has befallen him has enriched us and made us prouder of our brotherhood; every step upward or onward of his has made our paths easier and the heights seem

not so far away. . . . He has shown us how work could be made play, and how the real could be made ideal. Because of him our lives have been better, our successes more real, our failures less hard to bear, for through the tangled skein that spells life each of us knows that in him he has, and will always have, a teacher, a friend, and a true fellow student to the end of the chapter.

Dr. Osler himself, before leaving the United States for England, summed up his philosophy of life in these few words:

I have had three personal ideals. One to do the day's work well and not to bother about tomorrow. It has been urged that this is not a satisfactory ideal. It is; and there is not one which the student can carry with him into practice with greater effect. To it, more than to anything else, I owe whatever success I have had—to this power of settling down to the day's work and trying to do it well to the best of one's ability, and letting the future take care of itself.

The second ideal has been to act the Golden Rule, as far as in me lay, towards my professional brethren and towards the patients committed to my care.

And the third has been to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friends without pride and to be ready when the day of sorrow and grief came to meet it with the courage befitting a man. . . .

I have made mistakes, but they have been mistakes of the head not of the heart. I can truly say, and I take upon myself to witness, that in my sojourn among you:—

"I have loved no darkness,
Sophisticated no truth,
Nursed no delusion,
Allowed no fear."

And so it is that this year, one hundred years after the birth of this great physician, the medical world pays homage to him. Congratulations to the Johns Hopkins Bulletin, the Archives of Internal Medicine and the Bulletin of the History of Medicine for their excellent memorial numbers.

Peace of Mind

...my peace I leave with you.

At this season of special giving the physician may well reflect upon the opportunity which is his to be the means by which many persons may come into one of the greatest of gifts—peace of mind. His attention has too long been focused disproportionately upon the hypothetic somatic half of man. That the psychosomatic relationship is not new is attested by society. The present renaissance of interest in this aspect of medicine stems partly from the war experience in selective service. Individual integration of body and mind is certainly basic to sound social, national and international integration.

The biography of the brain is complete enough to make it clear that there is no promise of future betterment unless human nature finds an atmosphere in which self knowledge and self control are part of the day's adventure. What physician will question that modern society suffers from the fractious petulance of immaturity, even when it is no longer young? The violent impatience of ignorance, the ugly serpents of suspicion, greed and power politics continue to cut a wide swath through the habitations of peace in these postwar years. Why is peace so elusive? America is learning the hard way that it is not enough to rattle the money bags, to possess by far the most of the world's telephones and automobiles. The secret of power, the secret of progress, the secret of peace lies within. The starting point is the individual.

Psychosomatic medicine has belatedly gathered momentum in the medical literature of recent years. The idea that physical signs and symptoms of disease may be codetermined by emotional factors properly gains ground, and as this knowledge becomes more and more workable in medical practice, it cannot longer be confined to psychiatrists alone. At least 50 per cent of the cases a general practitioner observes in his office are said to belong to the field of psychosomatic medicine. If that is true, surely he ought to be able to apply psychiatric methods himself, other than those suggested by common sense, which cannot be taught. Certainly, medical students, not merely future psychiatrists but also future medical practitioners at large, should have more than casual knowledge of psychologic concepts and methods. No strict borderlines exist between clearly somatic and psychosomatic conditions. Psychology is therefore one of the skills the physician always needs at

the bedside, no matter what the disease. The old slogan that he does not have to treat sickness but sick persons comes more and more into its own as practitioners in general gain increasing knowledge of how to understand not only pathology but that delicate instrument which is personality. 'May some celestial surgeon stab their spirits wide awake' to the opportunity that awaits.

Dr. Elmer Lee Henderson Honored in London

At the Third General Assembly of the World Medical Association held in London in October, Dr. Elmer Lee Henderson of Louisville, Ky., was named president-elect. Dr. Henderson was one of the founders of this association, which was organized in Paris in September 1947. Delegates from about thirty countries were in attendance, and some fifty observers from other organizations were present.

This distinguished Kentucky surgeon, also president-elect of the American Medical Association, is a world figure in medicine who is amply endowed with the attributes essential to able leadership. Under his guidance the World Medical Association should make rapid progress in its worldwide mission.

Associated with Dr. Henderson in the activities of this organization is another eminent American physician, Dr. Louis H. Bauer of Hempstead, N. Y., who serves as secretary-general. Dr. Bauer is chairman of the Board of Trustees of the American Medical Association.

American Dream or Nightmare?

It was a timely warning indeed to which Gen. Dwight O. Eisenhower gave utterance when he recently said publicly that the American dream will turn into the American nightmare if the people of this country become slaves of the government. Furthermore, he made no understatement when he said, "Unless we understand the American dream, it may become the American nightmare. We believe in human dignity, in human rights not subject to arbitrary curtailment. We believe that these rights can be fully possessed and effectively exercised only so long as man asserts and maintains himself the master not the serf of institutions he creates."

Of all groups of citizens today, the medical profession is peculiarly situated to appreciate and

agree with the General's opinion that if human rights and freedoms are to flourish, government must operate "with its powers sharply defined and limited by the governed." Urging that citizens view critically every slightest reason or excuse for moving the line that separates governmental from individual responsibility, General Eisenhower continued, "If today, we never give up the efforts to determine—so far as each of us can—the probable effect of every new governmental proposal upon our personal freedom, we will be discharging one of our most acute responsibilities as American citizens." Certainly this responsibility falls heavily upon the physician at the present time, and may he have a discerning mind and clarity of vision.

For Better Community Health

Many local and state medical societies throughout the nation are cooperating effectively with local agencies, such as chambers of commerce, to bring about better community health conditions. Information regarding these cooperative efforts was gathered recently in a preliminary survey conducted by the Council on Medical Service of the American Medical Association. Questionnaires were sent to 165 state and county medical societies and to about 50 chambers of commerce executives. An analysis of the replies served as the basis for a course on community health leadership, conducted by the council's secretary at the twenty-sixth annual national institute for commercial and trade organization executives at Northwestern University. It was the first time that health as a community problem was included in the curriculum.

The study revealed that chambers of commerce can be of great help in working on various civic health programs, such as sanitation, polio prevention and child health, as well as in the collection of money for medical schools and foundations. Responses from several chambers of commerce stated that physicians are too often "medical men and not citizens." Those who are members of their local chamber of commerce are too frequently merely "paying members" rather than active participants in civic undertakings, the study showed.

How interested is your chamber of commerce in community health projects? The answer may depend to a surprising degree on how active a participant you are in its affairs.

Medical District Meetings, 1949

The fall meetings in the four medical districts were held in October. The brevity and conciseness of these one-day meetings enable many physicians throughout the state to meet their state officers and colleagues and at the same time to hear papers of scientific value.

Dr. Russell B. Carson, chairman of Council, the eight councilors, secretaries and committeemen of the host county medical societies, essayists and Association officers are to be commended on their efforts to make these meetings successful.

Dr. Walter C. Payne, president, mentioned briefly the theme of the message to be presented by the other officers. President Payne then took as his subject, "The Layman's Viewpoint on Medical Public Relations."

Dr. Herbert E. White, president-elect, used as the basis of his address, "Blue Shield."

Dr. Robert B. McIver, secretary-treasurer, was assigned the subject, "Problems of the Secretary-Treasurer." Dr. McIver reported that the Association's membership according to the current count is more than 2,000. This figure includes Life and Honorary members who do not pay state dues.

He also mentioned progress on plans for the Seventy-Sixth Annual Meeting to be held at the Hollywood Beach Hotel in April 1950.

The secretary introduced Mr. William Harold Parham and urged all present to make his acquaintance. Mr. Parham is scheduled to supervise the Association's Bureau of Public Relations and serve as field representative.

A \$10 increase in the Association's dues will be recommended to the House of Delegates by the Board of Governors, this increase to be effective January 1951. The estimated expense over income is \$11,260. This will just about wipe out all cash in bank checking accounts. This problem was presented at the medical district meetings in order that the delegates from the county societies may study the problem and come to the House of Delegates with an understanding of the reasons making it necessary to increase the state dues. President Payne requested the privilege of the floor and urged that all delegates have a thorough understanding of what will take place if the present program is curtailed for lack of funds.

Dr. Shaler Richardson, editor of *The Journal* was prevented from attending the meetings be-

cause of circumstances over which he had no control. Dr. Webster Merritt, assistant editor, discussed "The Journal" at the Palatka meeting and very forcefully emphasized the value of The Journal and the place in the Association's life that it holds.

Dr. Joseph S. Stewart, chairman of the Association's Committee on Public Relations discussed the state educational campaign which is a unit of the national campaign of the A. M. A. He also discussed plans which have been under way for the last year or two which would make it possible for county medical societies to accept Negro physicians as members. The Board of Governors will present this plan at the meeting of the House of Delegates in April.

Dr. Eugene G. Peek, chairman of the Association's committee on Legislation and Public Policy discussed "State Legislature Program." Dr. Peek made a very impressive and instructive address on what took place at the last session of the Legislature concerning medical and health bills that have to do with the well-being of the citizens of Florida.

The total registration of doctors and their guests at the four medical district meetings was 268.

Northwest Medical District — A

October 24 — Quincy

At the scientific assembly and the general session, Dr. Russell B. Carson and Dr. Taylor W. Griffin, councilor of district 2, presided at the meeting which was held at the Sawano Country Club.

Dr. Merritt R. Clements, president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, welcomed the members and guests as the meeting opened at 2:30 p.m.

Immediately following, Dr. Nathan Arenson of Pensacola, a member of the district spoke on "Multiple Small Bowel Intussusception." Dr. Edwin H. Andrews of Gainesville, the guest speaker, chose for his subject, "Consideration of the Pancreas in the Diagnosis of Upper Abdominal Diseases." A general discussion followed the reading of the papers.

Marianna was selected at the general session for the meeting place in 1950 at the invitation of Dr. Frank Watson, representing the Jackson County Medical Society.

Dr. Carson called on the officers of the State Association who responded with short talks on

matters of concern to all members of the Association.

Refreshments were served by the host society.

The total registration was 51, of which 42 were Association members (from A district, 34) and 9 were visitors. State Association officers present were: Walter C. Payne, president; Herbert E. White, president-elect; Robert B. McIver, secretary-treasurer; Eugene G. Peek, chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Russell B. Carson, chairman of Council; William P. Hixon, councilor of district 1 and Taylor W. Griffin, councilor of district 2.

Registration

CHATTAHOOCHEE: Irving T. Clark, Walter G. Miles, William D. Rogers. FT. LAUDERDALE: Russell B. Carson. GAINESVILLE: Edwin H. Andrews. GRACEVILLE: Redden L. Miller. HAVANA: James W. Sapp. JACKSONVILLE: James G. Lyerly, Robert B. McIver, Wilson T. Sowder, Stewart G. Thompson. LAKE CITY: Clifton G. York. MARIANNA: Albert E. McQuagge, Elmer J. Teagarden, Francis M. Watson. MONTICELLO: William L. Hunter. OCALA: Eugene G. Peek. PENSACOLA: Allen M. Ames, Nathan Arenson, Herbert L. Bryans, William P. Hixon, John J. McGuire, John C. McSweeney, Jr., Wendell J. Newcomb, Walter C. Payne, Gretchen V. Squires, Dale E. York. PORT ST. JOE: Albert L. Ward. QUINCY: Taylor W. Griffin, Edward C. Love, Jr., J. Lloyd Massey. ST. AUGUSTINE: Herbert E. White. TALLAHASSEE: Merritt R. Clements, Paul J. Coughlin, Laurie L. Dozier, Ernest W. Ekermeier, George H. Garmany, Arthur J. Henry, Jr., Francis T. Holland, Robert H. Mickler, Henry L. Smith, Jr., Benjamin A. Wilkinson.

VISITING DOCTORS—JACKSONVILLE: Knox E. Miller. PENSACOLA: Fred A. Butler. QUINCY: George H. Massey. TALLAHASSEE: Frank E. All, Clarence W. Ketchum, Raney A. Owen.

OTHER GUESTS—JACKSONVILLE: Mr. Wm. Harold Parham, Mr. Tom Stallworth.

Northeast Medical District — B

October 26 — Palatka

The meeting was held at the Elks' Club with Dr. Russell B. Carson, chairman of Council, and Dr. Cleland D. Cochrane, councilor of district 4, presiding.

At 2:35 p.m., members and guests were welcomed by Dr. Grover C. Collins, president of Putnam County Medical Society.

The scientific program was opened by Dr. Alphonsus M. McCarthy of Daytona Beach, district member, who presented a paper on "The Nonfunctioning Gallbladder." Dr. A. Fred Turner, Jr., also a district member, presented a paper on "A General Practitioner's Care of the Prostate." The floor was opened for discussion of the papers.

At the general session, Ocala was selected as the meeting place for 1950. The invitation was extended by Dr. Eugene G. Peek in behalf of the Marion County Medical Society.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments and dinner were served by the host society.

The total registration was 75, of which 71 were Association members (from B district, 65) and 4 were visitors. State Association officers and Committee Chairmen present were: Walter C. Payne, president; Herbert E. White, president-elect; Robert B. McIver, secretary-treasurer; Webster Merritt, assistant editor of *The Journal*; Turner Z. Cason, chairman of the Medical Postgraduate Course Committee; Eugene G. Peek, chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Russell B. Carson, chairman of Council; Cleland D. Cochrane, councilor of district 4.

Registration

COCOA: A. F. Thomas. CRESCENT CITY: James W. Davidson, Edward W. Ford, Bernard E. Kane. DAYTONA BEACH: James W. Clower, Jr., Cleland D. Cochrane, C. Robert DeArmas, Peter A. Drohomier, David W. Goddard, Alphonsus M. McCarthy, Achille A. Monaco, Lawrence J. Schneider, Norman E. Williams. FT. LAUDERDALE: Russell B. Carson. FERNANDINA: Henry B. Dickens, Jr. GAINESVILLE: F. Emory Bell, J. Maxey Dell, J. Maxey Dell, Jr., Albert G. Love, IV, James M. McClamroch, John E. Maines, Jr., George H. Putnam, Howard W. Reed, William C. Thomas. GRANDIN: James W. Brantley, GREEN COVE SPRINGS: John M. Malone. HAWTHORNE: George M. Floyd. JACKSONVILLE: Frederick H. Bowen, Turner Z. Cason, Banks H. Goodale, Karl B. Hanson, Edward Jelks, Robert B. McIver, Webster Merritt, Kenneth A. Morris, Lauren M. Sompayrac, Wilson T. Sowder, Walker Stamps, Wilbur C. Sumner, Stewart G. Thompson. LAKE CITY: Laurie J. Arnold, Jr., Thomas H. Bates, Robert B. Harkness. LEESBURG: Marion B. O'Kelley. MELBOURNE: Theodore J. Kaminski. NEW SMYRNA BEACH: William C. Chowning. OCALA: Bertrand F. Drake, Carl S. Lytle, Eugene G. Peek, Eugene G. Peek, Jr. ORLANDO: Chas. J. Collins, Roger W. Gridley, Robert P. Henderson, Gerald W. Jones, Newton C. McCollough, Robert G. Neill, Frank M. Parish, Roger E. Phillips, Louis E. Pohlman, W. Dean Steward, A. Fred Turner, Jr. PALATKA: Grover C. Collins, Lawrence G. Hebel, Claude M. Knight. PENSACOLA: Herbert L. Bryans, Walter C. Payne. ST. AUGUSTINE: Reddin Britt, Hardgrove S. Norris, Joseph A. Shelby, Herbert E. White. SANFORD: Harry Z. Silsby.

VISITING DOCTORS—GAINESVILLE: William C. Thomas, Jr. JACKSONVILLE: Knox E. Miller.

OTHER GUESTS—JACKSONVILLE: Mr. John C. Lee, Mr. W. Harold Parham.

Southwest Medical District — C

October 27 — Sebring

The meeting was held at the Sebring Hotel with Dr. Russell B. Carson, chairman of the Council, presiding at the scientific assembly and the general session. Dr. M. Crego Smith, councilor of district 5, and Dr. H. Quillian Jones, councilor of district 6, also were presiding officers.

Dr. John A. Simmons, president of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, welcomed the members and guests.

"Jaundice" was chosen by district member, Dr. Joseph C. Flynn, of Tampa, as the initial paper of the scientific program. Dr. Garland M. Johnson, guest speaker from Ft. Lauderdale, spoke on "The Toxic Effect of Tetra-Ethyl Pyrophosphate (T.E.P.P.)." Interesting discussions followed.

At the general session, Ft. Myers was selected as the meeting place in 1950. The invitation was extended by Dr. H. Quillian Jones in behalf of the Lee County Medical Society.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments were served by the host societies.

The total registration was 79, of which 71 were Association members (from C district, 63) and 8 were visitors. State Association officers and Committee Chairmen present were: Walter C. Payne, president; Herbert E. White, president-elect; Robert B. McIver, secretary-treasurer; Joseph S. Stewart, chairman of the Public Relations Committee; Eugene G. Peek, chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Russell B. Carson, chairman of Council; M. Crego Smith, councilor of district 5; H. Quillian Jones, councilor of district 6.

Registration

ARCADIA: Harold S. Agnew, Henry P. Bevis, F. Erwin Daves, Charles H. Kirkpatrick, Gordon H. McSwain, John A. Simmons. AVON PARK: Isaac W. Chandler, Hubert W. Coleman, Carl J. Larsen, Edwin C. Northup. BARTOW: Chester H. Murphy. BRADENTON: Lowrie W. Blake, William D. Sugg. CLEARWATER: William G. Mason, M. Crego Smith. DUNEDIN: John A. Mease, Jr. FT. LAUDERDALE: Russell B. Carson, Garland M. Johnson. FT. MYERS: William H. Grace, H. Quillian Jones. JACKSONVILLE: Robert B. McIver, Wilson T. Sowder, Stewart G. Thompson. LAKE LAND: Jere W. Annis, James R. Boulware, Jr., Charles H. Pette-way, Wylie L. Tillis, Edgar Watson. MIAMI: Joseph S. Stewart. MULBERRY: Milo H. Holden. OCALA: Eugene G. Peek. PENSACOLA: Herbert L. Bryans, Walter C. Payne. PUNTA GORDA: Roscoe S. Maxwell. ST. AUGUSTINE: Herbert E. White. ST. PETERSBURG: Abraham J. Gorday, James L. Gouaux. SARASOTA: John A. Butcher, Edward F. Meares, Henry G. Morton, Melvin M. Simmons. SEBRING: Leldon W. Martin, Zaven M. Seron, Stanley K. Wallace, Howard V. Weems. TAMPA: Chadbourne A. Andrews, Efrain C. Azmitia, Heyward J. Blackmon, Ernest R. Bourkard, Harold O. Brown, Herschel G. Cole, Lewis T. Corum, Oren A. Ellingson, J. Brown Farrior, Joseph C. Flynn, James C. Griffin, Jr., Samuel G. Hibbs, Ned W. Holland, James L. Estes, Paul J. McCloskey, Eugene B. Maxwell, David R. Murphey, Jr., Thomas F. Nelson, James N. Patterson, Lee T. Rector, Burdette Smith, Marshall E. Smith, William W. Trice, Jr., Morris Waisman, Wesley W. Wilson. WAUCHULA: Merle C. Kayton.

VISITING DOCTORS—ARCADIA: Fran J. Leddy. JACKSONVILLE: Knox E. Miller. SEBRING: Leroy J. Smith. TAMPA: Oscar A. Juarez, Lynwood B. Smith, James A. Winslow, Jr.

OTHER GUESTS—JACKSONVILLE: Mr. W. Harold Parham. TAMPA: Mr. Leonard Brown.

Southeast Medical District — D

October 28 — Ft. Lauderdale

Dr. Russell B. Carson, chairman of Council, and Dr. Erasmus B. Hardee, councilor of district 7, presided at the scientific assembly and the general session of the meeting which was held at the Trade Winds Hotel.

Dr. Paul G. Shell, president of the Broward County Medical Society, welcomed the members and guests.

Dr. Milton M. Coplan of Miami, a member of the district, opened the scientific program with his paper on "The Pathology of the Female Urethra—A Review." Dr. Henry Fuller of Lakeland, speaker by invitation, read a paper on "Observations on Digitoxin." Discussions followed.

At the general session, West Palm Beach was designated as the meeting place for 1950.

The chairman called on the officers of the State Association who responded with addresses of unusual interest.

Refreshments and dinner were served by the host society.

The total registration was 63, of which 54 were Association members (from D district, 46) and 9 were visitors. State Association officers and Committee Chairmen present were: Walter C. Payne, president; Herbert, E. White, president-elect; Robert B. McIver, secretary-treasurer; Joseph S. Stewart, chairman of the Public Relations Committee; Eugene G. Peek, chairman of the Legislation and Public Policy Committee; Stewart G. Thompson, managing director; Russell B. Carson, chairman of Council; Erasmus B. Hardee, councilor of district 7.

Registration

CORAL GABLES: Anna A. Darrow, T. D. Sandberg. FT. LAUDERDALE: Norris M. Beasley, Oliver C. Brown, Mark Butler, Russell B. Carson, Eugene C. Chamberlain, Frederick J. Driscoll, Leroy B. Elliston, Robert L. Elliston, Walter J. Glenn, Jr., Anne L. Hendricks, Elliott M. Hendricks, Paul W. Hughes, Garland M. Johnson, M. Austin Lovejoy, Lloyd U. Lumpkin, Richard A. Mills, Samuel P. Nixon, Albert A. Parrish, Francis D. Pierce, Raymond M. Price, Paul G. Shell, Curtis H. Sory, Frederick P. Swing, William D. Wells, Scottie J. Wilson. JACKSONVILLE: Robert B. McIver, Wilson T. Sowder, Stewart G. Thompson. LAKE LAND: Henry Fuller. MIAMI: Otto S. Dowlen, M. Jay Flipse, W. Tracy Haverfield, Walter C. Jones, Milton M. Coplan, Ralph S. Sappenfield, Oden A. Schaeffer, George F. Schmitt, Joseph S. Stewart, William M. Straight, Iva C. Youmans. MIAMI BEACH: Abraham Lustgarten. OCALA: Eugene G. Peek. PALM BEACH: Russell D. D. Hoover. PENSACOLA: Herbert

L. Bryans, Walter C. Payne. POMPANO: George S. McClellan. ST. AUGUSTINE: Herbert E. White. VERO BEACH: Erasmus B. Hardee. WEST PALM BEACH: Frederick K. Herpel, Theodore Norley, William Y. Sayad, James R. Sory.

VISITING DOCTORS—DANIA: Fred E. Brammer. FT. LAUDERDALE: Curtis D. Benton, Jr., Alfred E. Cronkite, William A. Exum. JACKSONVILLE: Knox E. Miller. MIAMI SHORES: Fred S. Wright. NORTH MIAMI: Charlotte K. Wilkins. WEST PALM BEACH: Joseph R. West.

OTHER GUESTS—JACKSONVILLE: Mr. W. Harold Parham.

YOUR BLUE SHIELD

Blue Shield Reminders

To the patient, the individual doctor represents not only the entire Blue Shield program but also reflects the interest of the entire medical profession. How successful your profession is in providing an alternate plan to socialized medicine schemes, depends to a large extent on the impression the patient gains when he visits your office.

Although you appreciate this responsibility, frequently office nurses, receptionists and bookkeepers do not have an adequate understanding of these relationships:

1. That Blue Shield is not just another "insurance company."
2. That Blue Shield has a responsibility beyond paying for medical care; and
3. That the entire medical profession has a vital interest in how every Blue Shield case is handled in each individual doctor's office.

Take a little time to tell each of your patients about voluntary, prepaid Blue Shield for taking care of the cost of surgical care. It is the best investment you can make.

Patients who have limited cash resources appreciate payments of Blue Shield allowances directly to the doctor—it relieves the demand on their pocket money. The greatest service Blue Shield can render you, our profession and our public, is the return of the clinic and free ward patient to the status of private patient care.

Many subscribers hesitate to ask you to complete your Blue Shield Doctor's Service Report when the fee is small. The voluntary prepaid medical care program sponsored by your medical society will not serve its mission if you do not cooperate even on the small accounts. It is up to you or your office assistant to ease this situation. It will promote better relations for you and your profession with the public.

If your medical claim report does not give suf-

ficient information the Blue Shield plan must write and ask for further details. It takes up your time as well as the Plan's, increases administrative expense and delays the settlement of your claim. The details of unusual cases should be reported in clinical details in order that the plan may make a proper medical appraisal of its obligations to you and your patient under the terms of the Blue Shield contract.

The Blue Shield Plan would like to know what you think of it. Do not hesitate to send in your comments or suggestions directly to the plan or through your county medical society. Letters from doctors receive top priority in the plan office.

Blue Shield is good reading in your waiting room. Most people read while they wait and there is no more appropriate reading in your waiting room than Blue Shield literature. We will supply all you need, at no charge, upon request. Use this opportunity to promote Blue Shield, the democratic way of protecting America's good health.

Don't miss a chance to promote your Blue Shield Plan. Perhaps some of your friends in key business positions could facilitate the enrolment of sizeable employee groups. Tell them about Blue Shield. Take every opportunity to give your plan a boost.

When submitting reports for X-ray in the doctor's office a great deal of time and unnecessary correspondence may be saved if the doctor will include in his report the information as to whether or not X-ray was taken within twenty-four hours of an accident for a fracture or dislocation. It should be pointed out that this is the only type of X-ray covered by Blue Shield in the doctor's office.

STATE BOARD OF HEALTH

Parathion

Parathion (O,O-diethyl O-p-nitrophenyl thiophosphate) is a new organic chemical which has recently come into wide use because it is a powerfully effective insecticide. At the same time it is extremely toxic to man. Already it has caused one death in Florida.

Exposures to parathion may occur where it is being diluted with other materials, as in insecticide plants, or where spray tanks are being filled in citrus groves or on truck farms. The pilot of a dusting plane may be exposed in the loading of

his plane or in the actual process of dusting.

Parathion may be absorbed into the body by inhalation or it may penetrate the skin. Inhalation of toxic quantities of parathion results in the rapid development of an acute poisoning. It stimulates the parasympathetic nervous system. The patient complains of headache, vertigo, dyspnea, and nausea. Vomiting and diarrhea may occur. Pin-point pupils are usually observed and sometimes pulmonary edema may develop as late as twelve hours after exposure.

Experience with this chemical would indicate that the most effective treatment is the administration of atropine to the point of tolerance. Some authorities advise placing the patient in an oxygen tent at once while others keep the patient under close supervision and use oxygen if early signs of pulmonary edema appear.

Prevention of parathion poisoning can be made completely effective by the rigid observance of certain precautions such as the use of exhaust ventilation, respirators, rubber garments and gloves, daily changes of working clothes, and daily showers. These precautions must be enforced by intelligent supervision. Until all persons handling parathion are sufficiently educated to protect themselves, occasional cases of poisoning may be expected to occur and it is felt that physicians should be on watch for such cases so as to be able to render rapid and effective treatment.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those who have come to the attention of The Journal.

Arthur H. Weiland of Coral Gables, local Civitan Club
Jack Q. Cleveland of Coral Gables, Miami Beach Men's Club of Temple Beth Sholem
Edward R. Annis of Miami, Miami Beach Men's Club of Temple Beth Sholem
Edward R. Annis of Miami, Miami Beach Lion's Club
Joseph S. Stewart of Miami, local Junior Chamber of Commerce
Harold Rand of Miami, Miami Beach Lion's Club
Richard F. Stover of Miami, Bryans Memorial Methodist Church Men's Club

John C. Ajac of Coral Gables, local Optimist's Club
Reuben B. Chrisman, Jr., of Miami, Coral Gables Rotary Club
H. Quillian Jones of Ft. Myers, local Rotary Club
James E. Thompson of Tarpon Springs, local Woman's Club
Edward R. Annis of Miami, local Chamber of Commerce program on Station WKAT

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Hugh A. Carithers of Jacksonville announce the birth of a daughter, Starr, on Oct. 10, 1949.

Dr. and Mrs. Julian Lustig of Miami Beach announce the birth of a daughter, Denise Julianne.

Dr. and Mrs. Eli Gralitz of Miami Beach announce the birth of a son, Richard Michael.

Dr. and Mrs. Lewis G. Glueckauf of Miami Beach announce the birth of a son, Robert Louis.

Marriages

Dr. John A. Ray of Mulberry and Miss Anna Marguerite Stiefel of Jacksonville were married on Oct. 1, 1949, in Jacksonville.

Deaths—Members

Marshall, Louis R., Jacksonville... Nov. 24, 1949
Watters, William H., Miami... Oct. 11, 1949

Deaths—Other Doctors

Erwin, Archie L., Nashville, Tenn... Aug. 6, 1949
Fulmer, Herbert C., Daytona Beach... 1949
Martin, Irl E., Ocklawaha... Nov. 4, 1949

STATE NEWS ITEMS

Dr. Walter C. Payne of Pensacola, president of the Association, was the guest speaker at the dedication exercises of the Duval County Medical Society's new home, the Sellers Auditorium, on October 4. The following day he addressed the fall board meeting of the state Woman's Auxiliary.

Dr. Knox E. Miller, former Medical Director of the U. S. Public Health Service, Region 8, Texas, has been named assistant to the state health officer, Dr. Wilson T. Sowder.

Coming to Florida from 36 years service with the U. S. Public Health Service, Dr. Miller is on terminal leave until January 1, 1950, at which time his final separation from service will be effective. A graduate of Johns Hopkins, he has held the medical directorship in Texas since 1940; has aided in the establishment of schools of public health at the Universities of Michigan and Minnesota and recently conducted a health survey in Milwaukee.

Thirty-four members of the Florida Medical Association registered at the 1949 annual meeting

of the American Academy of Ophthalmology and Otolaryngology which was held in Chicago in October. They are Drs. Eric H. Lenholt, Daytona Beach; Charles W. Boyd and W. Jerome Knauer, Jacksonville; Marion W. Hester, Lakeland; Andrew G. Brown, Mariano C. Caballero, Gail E. Chandler, Maurice I. Edelman, Ralph E. Kirsch, George W. Lawson and Kenneth S. Whitmer, Miami; Francis E. Denman, Walter T. Hotchkiss, Louis G. Lytton and John R. Richardson, Miami Beach; Ralph E. Russell and William H. Anderson, Jr., Ocala; Joseph Feldman, Palm Beach; Bernard M. Barrett, Chas. J. Heinberg, Mozart A. Lischkoff and Nathan S. Rubin, Pensacola; Paul T. Kope, St. Petersburg; Edson J. Andrews, Tallahassee; R. Renfro Duke, Thomas M. Edwards, J. Brown Farrior, Sherman B. Forbes, Blackburn W. Lowry, Hugh E. Parsons, Joseph W. Taylor and Frances C. Wilson, Tampa; William Y. Sayad and Younger A. Staton, West Palm Beach.

At the Conference of State Medical Association Secretaries and Editors held at the A.M.A. Headquarters Building, Chicago, November 3 and 4, Florida representatives were Drs. Robert B. McIver, Secretary and Webster Merritt, Assistant Editor of the Journal; Stewart G. Thompson, Managing Director and Ernest R. Gibson, Assistant.

The second annual Public Relations Conference convened on November 5 and 6. In addition to Dr. McIver, Thompson and Gibson, Dr. Reuben B. Chrisman, Jr., of Miami, was in attendance at the PR Conference representing Dade County Medical Association.

Among Florida doctors attending the thirty-fifth annual Clinical Congress of the American College of Surgeons which was held in Chicago, October 17-21 were Drs. Carl J. Larsen, Avon Park; Russell B. Carson, Ft. Lauderdale; George D. Lilly and James W. Merritt, Jr., Miami; Newton C. McCollough and Frank J. Pyle, Orlando; George W. Morse, Pensacola; Vernon A. Lockwood, St. Augustine; Thomasson P. Dann, and Irwin S. Leinbach, St. Petersburg; Herschel G. Cole and Mason Trupp, Tampa; Lauchlin M. Rozier and Younger A. Staton, West Palm Beach; and Theodore C. Keramidas, Winter Haven.

Drs. Carson, Keramidas, Leinbach, Lilly, Merritt, Lockwood, McCollough, Pyle, Staton and Trupp were elected as Fellows of the College of Surgeons.

Dr. Samuel R. Norris has returned to Jacksonville after attending the meetings of the American Society of Obstetricians, Gynecologists and Abdominal Surgeons in Hot Springs, Va., in September.

Dr. J. Harold Medlin has returned to Miami after attending a course in surgical anatomy, operative surgery, and clinical surgery at the Cook County Graduate School of Surgery in Chicago.

Dr. Wilson T. Sowder, Jacksonville, addressed a regional meeting of the Council for State Governments in Asheville, N. C., in September.

Dr. Samuel G. Hibbs has recently returned to his home in Tampa after attending a medical meeting in Philadelphia, Pa.

Dr. Clarence M. Sharp, Jacksonville, participated in the program of the Southern Tuberculosis Conference held in Memphis, Tenn., in September.

Dr. George F. Schmitt, Miami, recently completed a course in electrocardiography at the University of Michigan. While touring Mexico, he visited the Cardiological Institute in Mexico City and the medical facilities in Guatemala City.

Dr. Lee T. Rector has resumed his practice in Tampa following a visit to clinics in the Evans Memorial Hospital, Boston, Mass., and the New York Hospital, New York, N. Y.

Dr. Samuel S. Lombardo has opened an office in the St. James Building, Jacksonville, for the practice of general surgery and oncology, after several years in the army doing graduate work.

Dr. Willard L. Fitzgerald, Miami, announces that Dr. Merrick D. Thomas, Jr., has joined him in the practice of urology at 422 Ingraham Building.

Among the speakers on a health symposium conducted by the Cleveland Court School Parent-Teacher Association, Lakeland, were Drs. James R. Boulware, Jr., and S. L. Watson. Dr. Boulware selected as his subject, "Growing Healthy Bodies," while Dr. Watson chose "Sane Sex Information."

The regular fall meeting of the Florida State Pediatric Association was held in Orlando, October 29-30. Included in the list of 90 registrants were visiting pediatricians from Georgia and Alabama.

Dr. Wilson T. Sowder of Jacksonville has been reappointed Florida State Health Officer by Governor Warren for a four year term. Dr. Sowder has been State Health Officer since Sept. 15, 1945.

Dr. Carlos P. Lamar of Miami wishes to thank the many friends who "pulled for him" during his recent illness and to announce his complete recovery and return to his practice, limited to the diagnosis and management of diabetes and other endocrine disorders.

Dr. Frank G. Slaughter of Jacksonville addressed the fall Board meeting of the State Woman's Auxiliary on October 5 in Jacksonville.

Dr. Frank S. Whitman of West Palm Beach has returned to his practice following a trip to Baltimore, Md., where he engaged in postgraduate work in diagnosis and medicine.

Dr. Kenneth W. Schenck of Ft. Lauderdale is in New York doing graduate work in obstetrics and gynecology at New York University. He plans to return to his practice the first of the year.

Dr. Bricey M. Rhodes of Tallahassee has been named by Governor Warren to the State Board of Medical Examiners to succeed Dr. Howard G. Holland of Leesburg, whose term expired.

Dr. Charles E. Russell of Cocoa has returned to his practice after attending a Medical Reserve Officers meeting in Atlanta, Ga.

Dr. H. Phillip Hampton of Tampa has returned to his practice following a trip to Durham, N. C., where he took a special course at Duke University Hospital.

Dr. Ralph M. Overstreet, Jr., of West Palm Beach was the speaker at the meeting of the Registered Practical Nurses' Association in that city on Oct. 3, 1949. His subjects were cancer and drugs and their uses.

Dr. Frank G. Slaughter of Jacksonville has announced publication of his latest medical novel, "Divine Mistress," the plot of which revolves around the difficulties encountered by the early anatomists in the days of the Renaissance. Fancy intertwines with truth around the lives of Andreas Vesalius and Michael Servitus.

The American College of Surgeons will hold a sectional meeting at the Belleview-Biltmore hotel in Belleair on Jan. 9 and 10, 1950. This section is comprised of Virginia, North Carolina, South Carolina, Georgia, Mississippi, Alabama and Florida. Members of the Florida Medical Association and personnel of Florida Hospitals are invited to attend.

Dr. Lawrence R. Leviton of West Palm Beach has recently completed a brief course at the New York Postgraduate Medical School.

Medical Officers Returned

Dr. Jack M. Waldrep, who entered military service on Jan. 5, 1943, received his discharge on July 7, 1946. His address is 1206 E. Ocklawaha Avenue, Ocala. He held the rank of Captain.

Dr. Daniel R. Usdin, who entered military service on July 10, 1942, received his discharge on Jan. 3, 1946. His address is 2099 Park Street, Jacksonville. He held the rank of Captain in the U. S. Air Force.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bicknell, George F., North Miami
Branning, Bowman W., Miami
Branning, William S., Miami
Burtner, Otto W., Jr., Miami
Caballero, Mariano C., Miami
Carpousis, Aris, Washington, D. C.
Hayes, Candler K., Starke
Hendrix, John W., Port St. Joe
Hiatt, Wilks O., Jr., Ft. Lauderdale
Keeley, Joseph F., Jr., Miami
Kemp, Simon I., Miami
Lacy, George E., Baltimore, Md.
Maloney, Milton C., Jacksonville
Merlin, Hyman, Miami

Newbern, Walter R., West Palm Beach
Norley, Theodore, West Palm Beach
Palamar, Michael, Jacksonville
Pollen, William, Lake Butler
Price, Raymond M., Ft. Lauderdale
Rosenfeld, Charles, Miami
Smedley, John T., Miami
Steinman, William, Miami
Thompson, Richard P., Jacksonville
Wright, Jack L., Miami

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COMPONENT SOCIETY NOTES

Hillsborough

The entire membership of the Hillsborough County Medical Association has paid 1949 dues to the Association.

Jackson

All members of the Jackson County Medical Society have paid Association dues for 1949.

Marion

Dr. William H. Garvin, Jr., vice president of the Marion County Medical Society, officially conducted the regular monthly meeting on October 19, 1949, in the absence of President Robert E. Thompson. The meeting was held at the 1890 House in Ocala. Dr. Eugene G. Peek, Jr., submitted for consideration future evening meetings in conjunction with the Woman's Auxiliary.

Members present were as follows: Drs. William H. Anderson, Jr., Richard C. Cumming, Bertrand F. Drake, William H. Garvin, Jr., Henry L. Harrell, Eaton G. Lindner, John D. Lindner, Carl S. Lytle, William J. McGovern, Robbins Nettles, Eugene G. Peek, Eugene G. Peek, Jr., Jack M. Waldrep, Thos. H. Wallis and Harry F. Watt.

Palm Beach

All members of the Palm Beach County Medical Society have paid Association dues for 1949.

Pasco-Hernando-Citrus

The October meeting of the Pasco-Hernando-Citrus County Medical Society was held at the home of Dr. S. Carnes Harvard in Brooksville.

During the scientific portion of the meeting Dr. Harvard reported on a case of Klumpke's paralysis following accidental severance of the nerve in an automobile accident. Dr. William H. Garvin, Jr., guest from Dunnellon, gave an account of a case displaying marked unilateral body disproportion in size especially the tongue; and the case of a child with supracondylar fracture of the humerus—arterial pulsations occluded when the elbow flexed.

Members present in addition to Dr. Harvard included Drs. Donald G. Bradshaw, George R. Creekmore, W. Wardlaw Jones, Jere W. Kirkpatrick and William H. Walters, Jr. Drs. Karl T. Humes of Bushnell and Gail M. Osterhaut of Inverness were guests.



Pinellas

Dr. Albert R. Frederick, St. Petersburg, took office as president of the Pinellas County Medical Society at the October meeting in the Detroit hotel, replacing Dr. Francis H. Langley, St. Petersburg.

Dr. Claude B. Wright, St. Petersburg, is the newly elected president-elect. Other officers selected to serve during the current year with Dr. Frederick include: Dr. Everett M. Harrison, Clearwater, first vice president; Dr. William D. Futch, St. Petersburg, second vice president; and Dr. Whitman C. McConnell, St. Petersburg re-elected secretary-treasurer.

OBITUARIES

Robert Crawford Woodard

Dr. Robert C. Woodard of Miami died on Aug. 31, 1949 in the Woodard wing of the Jackson Memorial Hospital in that city, which was named in his honor in 1933. He was 81 years of age and had been actively engaged in general practice until a heart ailment caused him to enter the hospital a short time before his death.

Born in Berrien County, near Adel, Ga., Dec. 9, 1867, Dr. Woodard was graduated in 1899 from the University of Georgia School of Medicine in Augusta. He returned to Adel and practiced medicine there for twenty-two years. For fourteen years during this period he operated his own hospital. Keenly interested in education, he served as chairman of the board of education in Adel for twenty-one years and was active in the founding

of the Georgia State College for Women at Valdosta. Also interested in civic affairs, he served several terms in the Georgia state legislature.

In 1921, Dr. Woodard moved to Miami, where he continued to engage in general practice. Ten years later he was appointed superintendent of the Jackson Memorial Hospital. He served in this capacity from 1931 to 1940 and during his administration successfully promoted a program of expansion. Indicative of his continued interest in medical progress after a career of nearly half a century in medicine was his enrolment in post-graduate courses in cardiology in 1945-1946.

Dr. Woodard was a member of the Dade County Medical Association and the Florida Medical Association, and was a fellow of the American Medical Association. During the twenty-four years he held membership in the Florida Medical Association his active service included chairmanship of the Committee on Medical Education and Hospitals and necrologist for his district.

Surviving are five daughters, Mrs. Leila W. Hall, Mrs. Charles H. Alderman, Mrs. Gwen Pickle and Mrs. Jack A. McKenzie of Miami, and Mrs. Raymond Howe of Daytona Beach; a sister, Mrs. Lillie Knight of Miami; seven grandchildren and two great grandchildren.

Sheldon Stringer

Dr. Sheldon Stringer of Tampa died at the Tampa Municipal Hospital on Oct. 8, 1949 after a long illness. He had closed his office in that city Sept. 1, 1949 and had been recuperating at the home of a sister in Brooksville until it became necessary for him to be moved to the hospital. He was 66 years of age.

Dr. Stringer was born in Brooksville on June 23, 1883. He received his medical degree from the University College of Medicine, Richmond, Va., in 1905. That same year he was licensed to practice in the state. Following short periods in Brooksville and Key West he began practice in Tampa in 1906, serving there for forty-three years. For ten years he was surgeon in charge of the old Gordon Keller Hospital and later was the first superintendent of the Tampa Municipal Hospital.

Among the offices held by Dr. Stringer were city health officer, assistant surgeon for the United States Health Service, Tampa district, member of the state board of medical examiners during Governor Gilchrist's administration, surgeon on the examining board during the first World War

(Continued on page 383)

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Alexander Brunschwig	N. Y. Memorial Hospital	Operability of cancer
Meredith F. Campbell	New York	Urology
Louis K. Diamond	Harvard Medical School	RH factor
Arthur C. DeGraff	New York	Heart
Maxwell Finland	Harvard Medical School	New antibiotics
Richard H. Freyberg	Cornell University	Compound E in arthritis
Chevalier L. Jackson	Philadelphia	Bronchoscopy
Herbert C. Maier	N. Y. Presbyterian Hospital	Chest Surgery
James F. Norton	Margaret Hague Maternity Hospital	Extra peritoneal caesarean section
Eugene P. Pendergrass	Pennsylvania Hospital	X-ray
E. R. Pund	University of Georgia	Smear diagnosis of cancer
R. L. Sanders	Baptist Memorial Hospital, Memphis	Biliary and peptic ulcer surgery
Albert M. Snell	Mayo Clinic	Medical treatment of gallbladder and liver
Walter G. Stuck	San Antonio, Nix Memorial Hospital	Backache
Donald H. Stubbs	Walter Reed Medical Center	Vascular and circulatory collapse
Oscar Swineford	University of Virginia	Allergy
Willard O. Thompson	Chicago	Misuse of estrogens — obesity
Richard W. TeLinde	Johns Hopkins Hospital	Cancer in situ (cervix)
Julius L. Wilson	Tulane University	Chest disease
Harold G. Wolff	Cornell University	Headache

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and later president of the local board for pension examinations. He was a Seaboard Air Line Railway surgeon for many years and an honorary member of the New York and New England Association of Railway Surgeons and the Association of Military Surgeons of the United States.

A past president of the Hillsborough County Medical Association, he was a life member of the Florida Medical Association, with a record of forty-four years' continuous membership, and a fellow of the American Medical Association.

He was active in the Elks and Masonic lodges.

Surviving are his widow, the former Genevieve Giddens, to whom he was married in 1912; and a sister, Mrs. Marguerite Stringer Guinn of Brooksville.



Young Cleveland Lott

Dr. Young C. Lott of Miami died on Aug. 22, 1949 at the Jackson Memorial Hospital following an illness of several weeks, a victim of nephrosclerosis with uremia. He was 60 years of age.

Dr. Lott was born on Oct. 22, 1888, at Ocilla, Ga. He attended the Randolph Macon Military Academy at Bedford, Va., and Emory University in Atlanta. In 1912 he received his medical degree at the University of Louisville School of Medicine. After serving a residency at the New York Polyclinic Hospital, he became assistant to Dr. William Sharpe, professor of neurologic surgery at the New York Polyclinic Medical School and Hospital in New York City.

In World Wars I and II Dr. Lott served his country well. In the first war, leaving his post in New York to volunteer for service before the United States entered the conflict, he was attached to a British Medical Unit in London. Later, transferring to the American Army Medical Corps, he saw service in France. During the recent war, as a major in the National Guard, he was in charge of medical examinations of recruits in South Florida. Following World War I, Dr. Lott practiced in Albany, Ga., moving to Miami in 1924, where he engaged in general practice featuring obstetrics and gynecology. A member of the Dade County Medical Association and the Florida Medical Association, Dr. Lott was also a fellow of the American Medical Association. Fraternally, he was affiliated with the Masonic Order, holding the thirty-second degree in both York and Scottish Rites; the Veterans of Foreign Wars; and the

(Continued on page 384)



From where I sit *by Joe Marsh*

Clam Chowder Can Be Dynamite!

If Smiley Roberts is a friend of yours, like he is mine, and if you want to keep his friendship, like I do, don't let him hear you say that good clam chowder can be made without cream.

In New England, where Smiley comes from, friendships have been broken over tomatoes versus cream in clam chowder. Experts say that south of Boston the tomato reigns supreme, but north of Boston it's cream—or else!

From where I sit, whether it should have cream or tomatoes is simply a matter of taste. This is plain to anyone who doesn't come from clam chowder country.

What a great world this would be if we could all see that most prejudices are matters of taste only. Some like hot coffee. Some like it iced. Some people like a temperate glass of beer. Others prefer ice-cold lemonade. My grandmother used to say, "Prejudice that sees only what it pleases, cannot see very plain."

Joe Marsh

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Military Order of the World Wars. An amateur naturalist, he was a member of the South Florida Orchid Society.

Surviving him is his widow, Mrs. Mary Louise Saird Lott.

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TO THE
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MRS. RICHARD F. STOVER, Romance of Medicine.....*Miami*

Organization

Organization of the doctors' wives in this crucial period is the most important project of the Woman's Auxiliary throughout the country.

I call this a project because a concerted effort must be made by everyone interested in medicine to reach each woman whose husband is a physician in good standing and acquaint her with her personal responsibility to the profession. When this is achieved, she will voluntarily gravitate toward the organization formed to serve her husband.

There has been misinterpretation of the reasons for an Auxiliary. Those who are out of touch with the parent organization consider an Auxiliary a waste of effort because in the formation of it they emphasize a project attractive to all and seek a program suitable to all. When this fails, and it usually does because it is a cart before the horse procedure, a weak, indifferent organization results.

In this case, the purpose of the organization has been subordinated to its entertainments. Entertainment and accomplishment must follow, not lead the fellowship which is the blood stream of the Auxiliary.

To achieve this fellowship and maintain it, to become acquainted with the issues that affect our doctors, and through this education made available to Auxiliary members, enlighten the public through

our normal activities, we have a full time project which requires membership in an Auxiliary to accomplish.

One of our most serious detractors is the otherwise successful wife of a physician, who is uninformed and indifferent to the purposes of the organization but who has sufficient enthusiasm to protest the activity of those who believe in it.

She must be made aware that the old system of "divide and conquer" is directed at the medical men of this country. This force is attempting to undermine the foundations of American medicine and by infiltrating gaps in unity will ensnare the unsuspecting and use them as weapons against their own profession.

She must be encouraged to educate herself in the issues which affect her husband's welfare and reinforce his stand to combat this encroachment upon his freedom.

At no time have the public relations of a doctor's wife been of more importance. She must practice self-restraint in conversation and pledge loyalty to the organization her husband respects enough to value and maintain membership. A derogatory word, a whispered detraction, a superficial attitude toward other doctors, their wives or their organizations, deals a blow, none the less deadly for its surreptitiousness, to the profession already under attack. Our ethics of behavior are as mandatory and essential to the community as the ethics doctors have pledged to uphold.

The objective: "To cultivate friendly relations and promote mutual understanding among physicians' families" is a vital spearhead in our drive for unity and will require maturity and intelligence to achieve.

The mistaken notion that we must dearly love and be compatible in all things with all members of the Auxiliary or not join, is as erroneous in concept as feeling we must personally approve of every member in our church or turn our backs on religion. The cohesive quality of religion lies in the freedom of all men regardless of their difference to gather and serve in what they believe.

If we would incorporate our spiritual concept into our social pattern and practice, "in so far as we are able, have peace with all men" our increase in numbers would form a bulwark against the enlarging trend which subscribes to the theory that "any measure, though it were absurd may be imposed upon a people if only you can get sufficient voices to make it law."

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 20. Vaginal Approach to Pelvic Surgery, One Week, starting March 6.

OBSTETRICS—Intensive Course, Two Weeks, starting March 6.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Gastroscopy, Two Weeks, starting March 6.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic & Lecture Course First Monday of every month. Clinical Course Third Monday of every month. X-Ray Therapy every two weeks.

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JAMES N. BRAWNER, JR., M.D., Department for Women

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochran, Daytona Beach	
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	
Florida Specialty Societies			
Allergy Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Heart Association	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewit, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	June 3, '50
Dental Society, State	T. C. Henslee, D.D.S., Miami	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Mr. H. Louie Wilson, Gainesville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Frank D. Gray, Orlando	Jacksonville
Medical Examining Board	James L. Borland, Jacksonville	Chairman	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Miss Helen Shearston, Miami	Panama City, October, 1950
Nurses Association, State	Miss Undine Sams, Miami	Mr. R. Q. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, March 30-31, '50
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. W. Lull, Chicago	Washington, D. C., Dec. 6-9, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	C. P. Loranz, Birmingham	Birmingham, Apr. 20-22, '50
Southern Medical Association	Oscar B. Hunter, Washington, D. C.	Douglas L. Cannon, Montgomery	Macon, Apr. 18-21, '50
Alabama Medical Association	Frank C. Wilson, Birmingham	Edgar D. Shanks, Atlanta	St. Petersburg, April 5-7, '50
Georgia Medical Assn. of	Enoch Callaway, La Grange, Ga.	Mr. L. H. Gunter, Montgomery	Columbia, S. C., Feb. 11-12, '50
S. E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Kath. B. MacInnis, Columbia, S. C.	Edgewater Park, Miss., Feb. 1
Southeastern Allergy Assn.	James Swineford, Charlottesville, Va.	Russell B. Carson, Ft. Lauderdale	Washington, D. C., Mar. 6-9, '50
Southeastern, Am. Urological Assn.	Osmer J. Ravenel, Charleston, S. C.	B. T. Beasley, Atlanta	
Southeastern Surgical Congress	R. J. Wilkinson	Arthur J. Butt, Jr., Pensacola	
Gulf Coast Clinical Society	Sidney G. Kennedy, Jr., Pensacola		

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Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Wewahitchka	3rd Tuesday Odd Months	7	100%	
Jackson *Calhoun	Daniel A. McKinnon, M.D. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	100%	A-1-50 William P. Hixon, M.D. Pensacola
Walton-Okaloosa	Arthur G. Williams, Sr. Lakewood	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	15	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	16	100%	
Leon-Gadsden- Liberty-Wakulla- Jefferson	Merritt R. Clements, M.D. 1232 N. Monroe Street Tallahassee	Edward C. Love, Jr., M.D. Masonic Temple Bldg. Quincy	Quarterly 7:30 P.M.	46	45	A-2-51 Taylor W. Griffin, M.D. Quincy
Suwannee	Joshua M. Price, M.D. Live Oak	Irby H. Black, M.D. 918 W. Howard St. Live Oak		6	100%	
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Taylor *Dirie-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	3	200
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Marion *Levy	Robert E. Thompson, M.D. Holder Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	31	29	
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Polk	Byron Y. Pennington, M.D. Lake Wales	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	79	76	509
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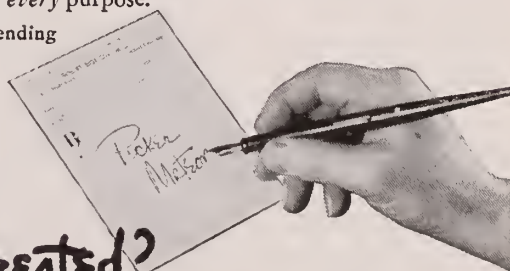
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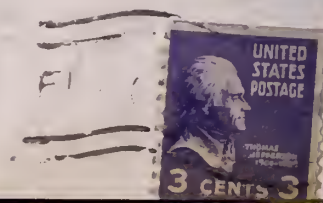
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

JANUARY, 1950

No. 7

IN THIS ISSUE

The Circus

Joseph Halton



Tetraethylpyrophosphate

Garland M. Johnson



Electrocardiography

Francis A. Reed



Britain's Health Program

An Editorial

M S D

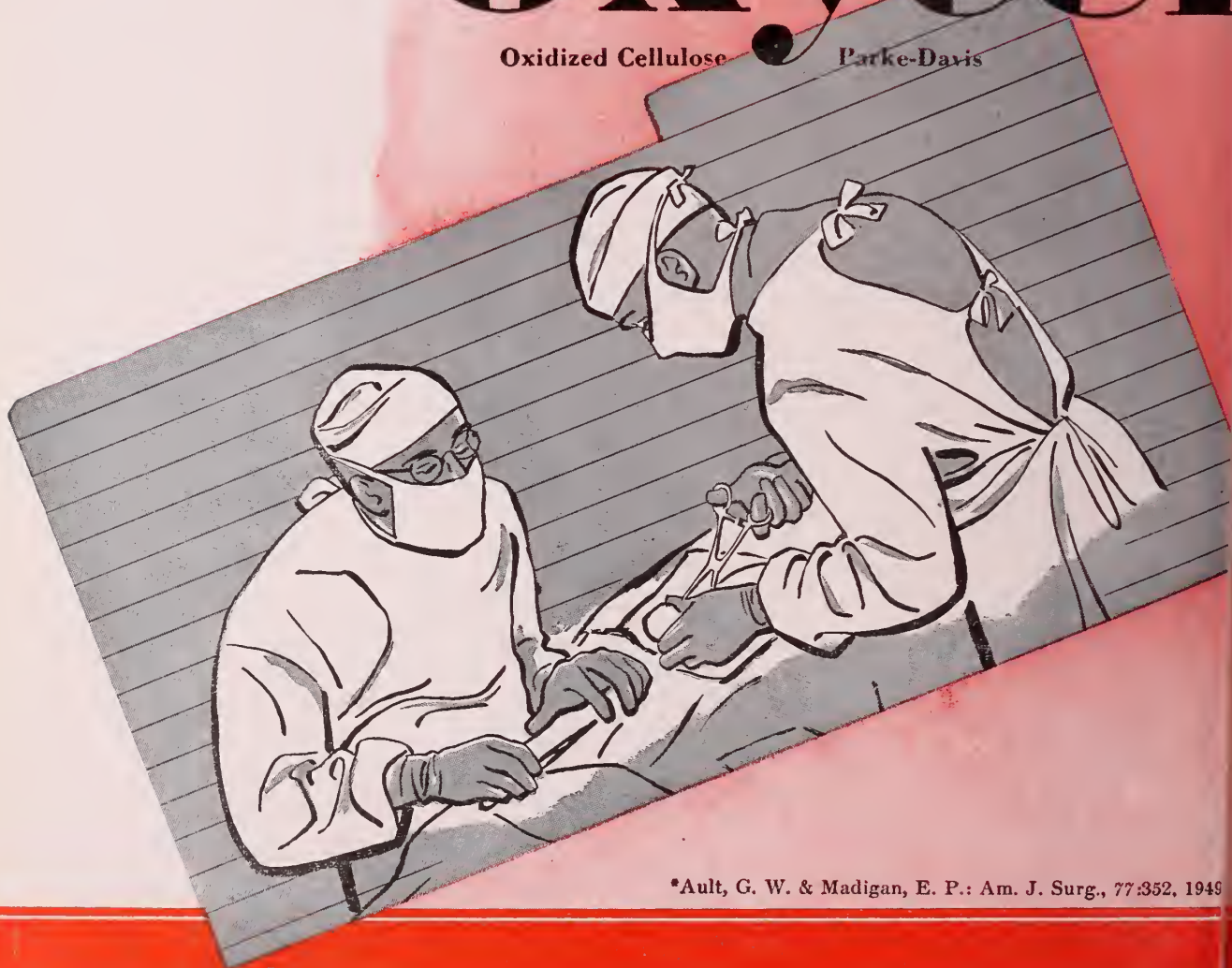
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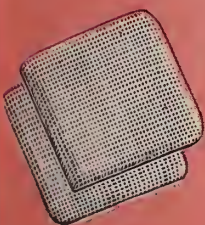
*Ault, G. W. & Madigan, E. P.: Am. J. Surg., 77:352, 1949

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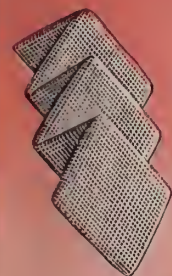
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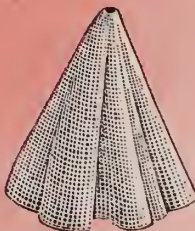
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CONTENTS

SCIENTIFIC ARTICLES

The Circus, Joseph Halton, M.D.	411
Comments on Diverticula of the Gastrointestinal Tract, Gerard Raap, M.D.	415
Toxic Effects of Tetraethylpyrophosphate: Report of a Case, Garland M. Johnson, M.D.	417
Clinical Application of Electrocardiography, Francis A. Reed, M.D.	420
Reliability of Serologic Examinations as Performed in Medical Laboratories in Florida, Albert V. Hardy, M.D.	427

ABSTRACTS OF MEDICAL ARTICLES

Drs. Paul N. Unger, Joseph Farrington, Chas. J. Collins, Nelson Zivitz and Julius A. Oshlag, Walter T. Hotchkiss, John W. Snyder and Emil M. Isberg	429-431
---	---------

EDITORIALS

Britain's Health Program Presented at University of Florida	434
1950 Preview	435
The 1949 Epidemic of Investigations F. M. A. Headquarters Visited	436

COMMENTARIES

Rural Health Conference	436
American Academy of General Practice	436
A. M. A. Washington Representative Visits Florida	437

GENERAL FEATURES

Officers and Committees	432, 433
Your Blue Shield	437
Births, Marriages and Deaths	438
State News Items	438
Component Society Notes	440
Obituaries	440
Woman's Auxiliary	445
Books Received	447
Schedule of Meetings	454

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

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*Joslin, E. P., Postgrad. Med.: 4:302 (Oct.) 1948.

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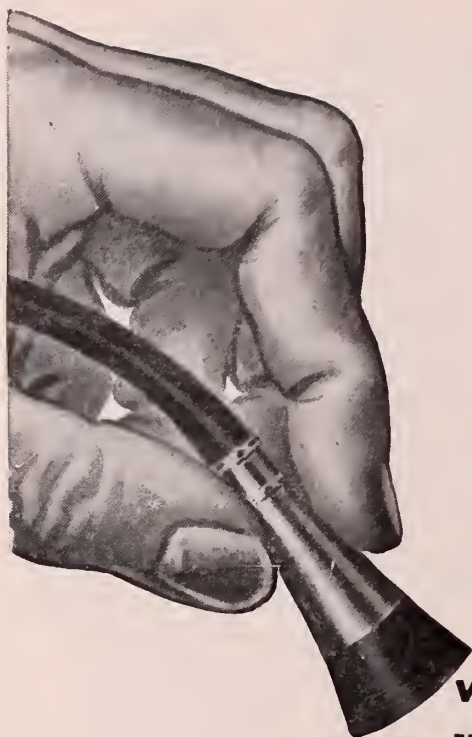


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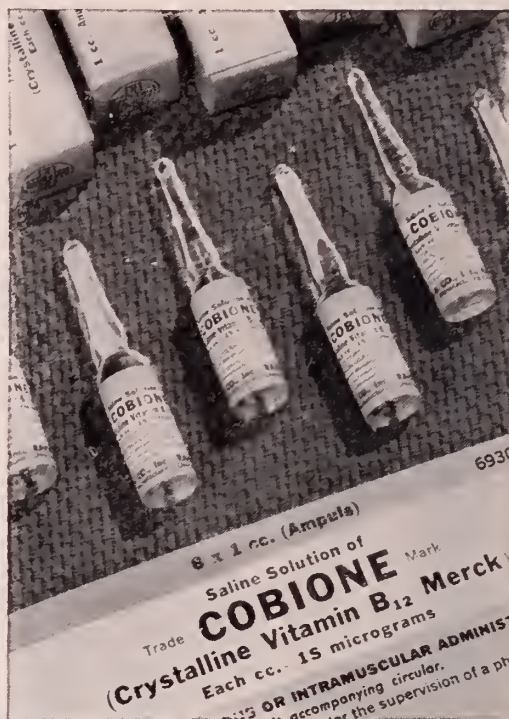
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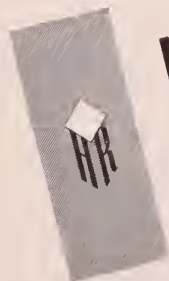
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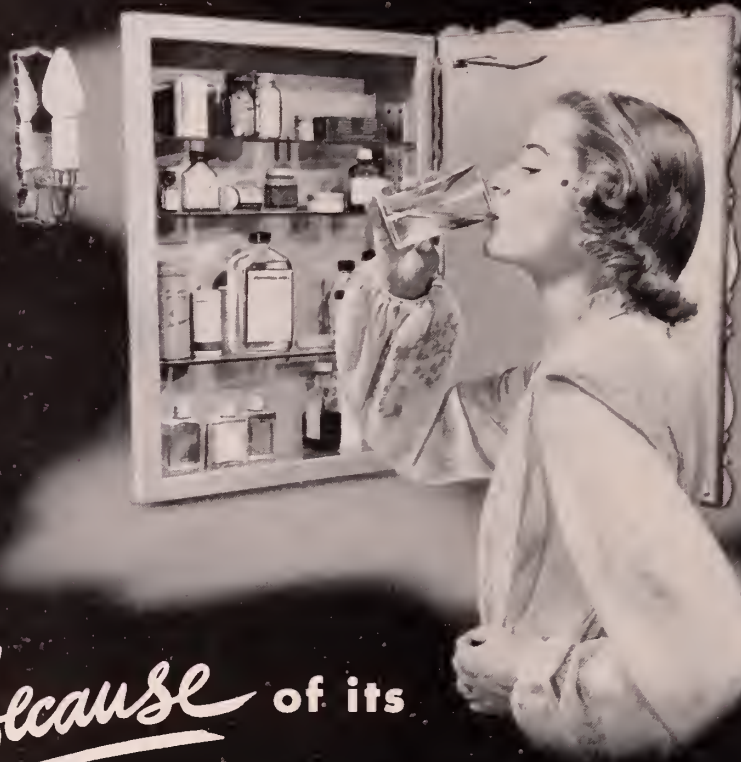
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The Circus

JOSEPH HALTON, M.D.

SARASOTA

It is always a great day when the Circus comes to town. When the Ringling Brothers Circus came to our town, it had come to stay for it had moved its Winter Quarters from Bridgeport, Conn., to Sarasota. The real estate fellows needled themselves with dreams of future sales. To them it was the promised day of Israel. The Circus is an industry. It has a payroll. Thirty thousand people visit the Winter Quarters each year.

There were originally five Ringling brothers and one sister. Alf, John and Charles were patients of mine. All are now dead. Alf was the real circus brains, a stickler for proper conduct, a fanatic on the morals of the personnel. Charles was the sharp intellectual type, John the exhibitionist.

My contact with the Circus came through the illness of the orangutans. They were dying rapidly. I made twenty postmortem examinations. They all died from tuberculosis. The orangutans are stupid, surly animals. You have to be ever on your guard as their little trick is to grab you, or any other monk, by the hand and bite off the fingers.

Miss Congo was the first gorilla with whom I came in contact. When Professor Yerkes of the Peabody Institute of Yale came to Sarasota to make studies on the intelligence of Miss Congo, I had a happy time with him. In one test we hung bananas in the top of the cage. With a series of blocks, Miss Congo would build an arrangement whereby she could attain the height necessary to reach the bananas. When she died, I sent her brain to Carnegie Institute for a study of comparative anatomy with the brain of a girl 16 years of age. My findings are recorded in Professor Yerkes' book entitled "Almost Human." From Miss Congo, I went to John's favorite chimpanzee, which he kept at his Italian villa. This chimpanzee died of tuberculosis.

Then came the gorilla—Gargantua. He was the meanest creature of them all and for good reason. To get even with the first mate of an ocean liner for some ill treatment a sailor thought he had received, the sailor threw a cup of nitric acid into the face of Gargantua, which accounts for Gargantua's distorted smile. Answering a call to the Winter Quarters to see Gargantua, who attendants thought was dying with dysentery, I took a 4 ounce bottle of paregoric and bismuth mixture. I always made 5 gallons of this mixture for the traveling doctor to take along when the Circus went on the road. This prescription I got from Dr. Steele, who had traveled with the Circus for thirty years.

There lay Gargantua limp as a rag, flat on his back with his head between the iron bars of his cage. I slowly poured the whole four ounces of Dr. Steele's favorite prescription down his throat. Not a pleasant job, as this brute had a lightning sweep of his paws that you could not dodge. John Ringling North found this out; I stitched up John North, and he stayed away from Gargantua. Gargantua did not die, or here my story would end. Six months later, I strolled to the cage. When he saw me, he reared up full height and fastened those mesmerizing eyes upon me. It was time for his loaf of raisin bread and quart of milk. So I fed him. He put on no act with me. When kindness has been shown to animals, there is some peculiar mental reaction between them and human beings.

The Psychology of the Circus

The attendance of the Circus is a study in mob psychology. People want to herd up or be with others of the tribe. They want to see how the other fellow acts when herded together with his kind. They are looking for different pastures. They want a change. On analysis, they want to see that fellow at the top of the tent take a chance

on breaking his neck. If he misses his count by a split second, his is a blackout. The crowd has had a thrill. Some are shocked. Others have had a Roman holiday. Let a Lillian Leitzel fall from the Big Top today and the show will play to a packed tent for the next two months. It will be interesting to this observer to note the gate attendance when the Circus returns to the state of Connecticut where the terrible fire occurred.

The Personnel of the Circus

The Great Loyal Rapenkeys, the Reffinacs, the Wallendas, the Lillian Leitzels, and many of the artists are not the course type of stake drivers that many people may think. They have a royalty of their own; seldom do they marry outside their class. Many date their ancestors to Queen Antoinette. The large percentage are foreign-born. Many of the men have seen service with the French Foreign Legion. They speak two or three languages and are well read. Their long life in contact with the public has made kindness a great virtue. Their sympathy for each other in time of need pulls the heartstrings of the thoughtful. They have large families and are devout Catholics. They are natural troubadours. No dirty gypsies in their society. No confidence men. They detest a phony. Phony is a word they use to express their disgust for make-believe persons. You see, their lives are real and they are keenly alive to anything that might cause someone to miss the count whether he be on the trapeze, in the tumbling act or in the daily walks of life. When mistakes are made, their generosity in forgiving would please the heart of a saint. They will leave the Big Top, but they will return. The doctors who travel with the Circus are the type of physicians who react to the wanderlust that many times assails you and me. How often would you like to take the wings of the morning and fly to the uttermost parts of the earth? Last year, I asked the physician, "What kind of a season did you have; were there many accidents or deaths?" He replied, "About 15 deaths but few accidents." Most accidents occur with the roughnecks who do the manual work. They travel with the Circus—sort of camp followers. The Circus management tries to keep them from too much drinking. Impossible—drinking is their escape.

The death of Charles Ringling was a great loss to the Circus. He contracted virus pneumonia in Atlanta. He was convalescing when I called to

make my dismissal visit. On arrival, the palatial home was empty. The family were in the swimming pool. In a chair was Charles, dying from what appeared to be an infarct. I pushed all the buttons, whistled and called. No answer. I threw a chair through a glass porch door; they all came running. Nothing attracts attention like broken and falling glass. John was next door. He came over. Charles died in a few hours. The family left the room except John and me. In the quietude that hung over the room, John said, "Joe, I am the last on the lot." If you do not understand that Circus phrase, you should be on the lot after the Circus has gone. It is a queer feeling. There are ghosts about. You think of Kipling's "The captains and the kings depart."

There are many experiences in the daily lives of the Circus people. Humor predominates in them all. Their laughter is spontaneous and infectious. When the Circus goes off the road, they have one week in Sarasota of goodbye parties and what a time. Too much drinking—no. Moderation to these people is just as true a sign of great men as excess is of weak men.

After the week ends, they start the repairs of clothing. The women have a fine art of needlework. The men attend to new acts and new rigging. The women used to make their own costumes; but the Circus has been modernized, and that task is assigned to the specialist. During the off season, away they go to all parts of the Western Hemisphere. Some are off to shrine circuses and winter fairs, others to various countries in South America and Cuba. In the spring they assemble in Madison Square Garden in New York a week before the opening. Many acts are assembled and the actors trained in the Winter Quarters at Sarasota many weeks before. The ballet teacher arrives. New costumes are fitted. Merle Evans is leading the band. The clowns are there. The elephants are in the Big Top. The rehearsal for the grand "Speck" (or spectacle) is taking shape. One is absent. Fred Bradna. He was the grand dominie who blew the whistle and cracked the whip for forty years. At the uplift of the hand, Merle Evans' band changes the tune from the "Blue Danube" to "A Hot Time in the Old Town" with never a missed beat. Fred Bradna is missing. The reason—while he was trying to save others, a tent pole fell across him, breaking both hips. They have done away with the whistle.

I Operate on an Elephant

It is said, "An elephant never forgets." I believe this to be true. If one does forget this incident, I certainly will not. Mr. Sam Gumpertz called me one day and said, "Dr. Joe, we have an elephant that is going to die. He represents about eight thousand dollars. We hate to lose him." Some months previously, the animal had had an abscess of his right shoulder. For a few weeks he had had another one at his right knee that needed opening. What should I take to cut through the hide of an elephant? I took every cutting tool I had.

On arrival, I found the preoperative preparations had been taken care of. The elephant had been well soaped, as had also the cement floor. Hay had been piled on the left side of him to lessen his fall when attendants applied the anesthetic by which he was to be under control. They had put a harness around his body which was connected to a three way block and tackle. Eight men began to pull. It was an impressive sight to see the strength of the elephant pitted against the ingenuity of man. How that animal braced himself against the pull. He enjoyed it. He did not rear or buck. He thought they could not do it. He, like a good sport, was willing for the try. They slipped one over on him. When they had him at the right angle, two fellows with stake sledge hammers knocked his feet from under him, and down he went on the hay where they fastened him prior to the operation.

While the anesthetic was being administered, I looked over the operating room and definitely picked the window through which I was going if anything about the paraphernalia busted. I tried to cut into the abscess. I had brought an old phalangeal saw. It was a saw that men in the past used to amputate the phalanges. From out of the past, I had the instrument to cut or saw through the elephant's hide. I needed a probe. We utilized bailing wire that was around a bale of hay. A 4 foot fistula extended from knee to shoulder. My hands gave out in laying wide this tract; so I had a couple of flunkies continue the cutting. We laid it open, washed it out with the hose, and the operation was finished. So was I. When I started to cut that elephant, he lay as still as a mouse. He certainly was a cooperative patient. Postoperative directions: wash the wound out with a hose daily. Results: anatomically 100 per cent; functionally 100 per cent; economically for me? You guess on an eight thousand dollar patient.

The Sex Life of the Hippopotamus

Little did the male hippo know his loved one was arriving on a flat car. Nor did I until they began bringing in the injured. After fixing up five men, I got the history. Monday was the day. The flunkies were sleeping off their week-end debauch, beneath the palm trees. It was a lovely, quiet, semitropical day. The moss floated lazily in the breeze. The palm trees nodded their heads in sleepy lullabies. Then, by way of prelude, with the whistle wide open, escaping steam, screeching brakes and blackened smoke, the railroad train delivered the bride. It must have been that once in this universe the wind blew both ways at the same time. Down went the iron fence around the pool. Crash went the wooden sides of the flat car. The flunkies were forthwith awake and in action. The fight they thought was on. The meddlers were in for treatment. One of the flunkies philosophized by stating, "That's what you get for messing up somebody else's fun."

The Black Panther

The fellow from the cathouse wanted to know if I would take an x-ray picture of his favorite cat. He thought she had lung trouble. "Sure, bring her in," said I. In due time, three nurses came running down the hall, one exclaiming, "Ye gods, Doctor, go see what they have on the elevator." I dern near fell down the shaft. This fellow had the biggest black panther I had ever seen. It was 6 feet long. I yelled, "What about him, Jim?" He said, "She is as good as a house cat." I placed three 14 x 17 cassettes under her and developed the film. Sure enough, she had lung trouble. Pneumonia. When I looked at those claws, I did not feel comfortable. The claws of the lion and the cats, as they call them, are very infectious. The foulest smelling abscess I ever opened, however, was from the bite of a camel.

His Majesty—the Camel

Three camels had dropped dead. I decided I would perform an autopsy on one, remove the stomach and take it to Dr. Herbert Mills, the pathologist, for examination. We removed the stomach in toto, especially ligating both ends securely. That was the sanest thing I ever did. The stomach weighed 80 pounds. It took a bunch of flunkies to get it into the rumble seat of my Henry Ford. We had wrapped it in a large piece of tent canvas and securely laced it with stout tent ropes. The day was hot. The roads to Tampa were not

as those of today. It is now 50 miles to Tampa; then, it was 90. We wound, twisted, and dodged pine trees all the way through loose and deep sand until the royal stomach began to think he was back in the desert. By now this specimen became a personal thing, who was by his stench and rapid distention in the hot July sun giving me personal combat. He was getting nasty. I thought of the poet, Robert Service, and his book, "The Spell of the Yukon" with the poem, "The Cremation of Sam McGee." Remember the struggle he had with the frozen corpse? So on the road to Tampa we went. He (the stomach) was in the rumble seat and in that hot July sun was storing up his flatus like an organ blower awaiting the first note before the curtain call.

At our destination, he, like many a puffed-up person, had expanded to all the nooks and crevices of the rumble seat. Extraction was impossible. I deflated his stinking highness with an ice pick. By this time, he had a real body odor that you could actually taste. Into the freezing compartment we placed him until the morrow. When I registered at the hotel, people around the desk and in the elevators began to examine the soles of their shoes. Dr. Mills opened the stomach, and there was the cause. Piercing the mucosa of the stomach were numerous pieces of bailing wire, barbs from barbed wire and staples. In one section of a specimen for biopsy Dr. Mills found tetanus bacilli.

The Giraffe

Somebody said someone was poisoning the giraffe. Did you ever stop to think how much poison it would take to kill a giraffe? I did not believe it. So with hammer, saw, crowbar and maul, I made a postmortem examination of a giraffe. The stomach revealed nothing. Then a dumb flunkie yelled, "Doc, he got it in the neck." I had forgotten about the hemorrhage. I had just returned from the Mayo Clinic where there had been talk about esophageal varicosities. So on and

up we went on the esophageal highway and found nothing.

The Death of the Ubangi Chieftain

From the Belgian Congo came the Chieftain of the Tribe of the Big Lips with his twelve wives, whose underlips contained a wooden disk the size of a meat platter. The disk was placed there in early childhood and replaced with increasing sizes as the age advanced. The objective—to make the women so repulsive that warriors from other tribes would not lead them into captivity. The Chieftain was a handsome specimen of the colored blood. The tsetse fly, malaria, syphilis and intestinal parasites had played no part in his development. He must have been one of nature's favored children. Acute mastoiditis laid him low at the Crile Clinic. Apparently everything had healed, but there was pus following the fascial planes of the neck. It was obligatory that a neck dissection be done. He had a blood stream infection. All we had at that time was the intravenous injection of mercurochrome. No sulfonamides or penicillin.

The hospital sounded like a duck pond when the twelve wives came to visit their Chief. The quack, quack, quack of the wooden disks in their lower lips was heard throughout the halls. They were like a happy crowd of children. The Chieftain with all his dignity and poise felt a presentiment that his days were numbered. He began preparation for his last safari. Each morning he faced the east with the top sheet of his bedding draped over his head. A low chant was heard. Not a muscular movement could be observed. At eventide, at the setting of the sun, he faced the west and repeated the same maneuvers. In a few days, his ability to stand was at an end. With sheet about his head, he sat in a chair, and with the thump, thump, bump of his naked heels upon the floor in symphonic timing with his chant of death, the Ubangi Chieftain returned to the Spirit Land of the Congo.

Pineapple Avenue.

Seventy-Sixth Annual Convention
Florida Medical Association
Hollywood, April 23-26, 1950

Comments on Diverticula of the Gastrointestinal Tract

GERARD RAAP, M.D.
MIAMI

In this paper, it is not the purpose to give a didactic survey of diverticulosis and diverticulitis, but rather to discuss the common and rare sites for which diverticula have predilection, their relative frequency and the problems both in diagnosis and therapy with which we as clinicians and radiologists have to deal. Allow me then the privilege of a few paragraphs of generalization which I think are the meat of this essay, followed by a classification of these diverticula, and then I shall show slides demonstrating the problems with which my associates and I have had personal experiences.

Diverticula occur anywhere along the entire intestinal tract or, in ordinary parlance, they occur wherever you find them. I am convinced that many are missed even though we as radiologists have tried to set up a routine of examination which purposes to give us the maximum in information. This statement is based upon the fact that many of the cases which we have been able to prove usually presented the evidence not on the first examination, but upon resurvey of what was thought to be a problem case.

It gives me satisfaction to be able to digress for a moment in stating that this observation illustrates what we radiologists have for a long time tried to emphasize to you as referring clinicians. There is a fairly large percentage of cases in which we survey the gastrointestinal tract and after eliminating certain major possibilities, we do not have a clearcut diagnosis to offer in explanation of a patient's symptoms.

I am reminded of a personal incident in which I found that at certain speeds there was a "foreign" noise under my automobile hood. After three visits to my mechanic, without results, I became somewhat irritated and asked why he could not find the cause of trouble. Yes, I had paid for new spark plugs, a new muffler and several gaskets and other things, but the offending noise still

persisted. And then the mechanic turned to me and said, "Well, Doc, we're doing the same thing you doctors do, just practicing!" And so we, too, must in many cases ask for indulgence while we sort the chaff from the wheat in our findings.

And here is a clinical illustration which brings out several points along the line of this generalization.

Report of Case

Mr. W. W., aged 76, had been in good health throughout life. Recently, he had experienced pain along the left costal margin which at times was sufficient to cause vomiting. His physician, a cardiologist, stated that in his initial cardiac survey he found nothing, but still realized that the pain could be of cardiac origin. In a routine gastrointestinal survey we were asked to pay particular attention to the possibility of hiatal hernia as a cause for symptoms. The patient was complaining of pain on his initial roentgen examination, and after ruling out hiatal hernia we noted a peculiar filling defect and tenderness together with a palpable mass which seemed to arise in the midthird of the stomach on the greater curve. The obvious suspicion was that of malignant disease of the left upper quadrant. The following day he returned stating that the pain was gone. As he had had food in the meantime, we were in no position to repeat the examination of the stomach. The colon and diaphragm showed nothing. We frankly stated that although we suspected gastric malignant disease, we could not explain these changes in symptomatology and asked for a recheck when convenient. Upon re-examination, the stomach appeared normal, but in the jejunum there was a peculiar split in the course of the barium column which intrigued us, and so after talking about horses for a while we made additional roentgenograms and found a huge diverticulum of the jejunum. This explained the mass, the filling defect, the pain which left suddenly and the reason we did not discover it in our first examination.

General Observations

Let me emphasize then, first, that you will find diverticula more easily when the pain is absent, and then filling is often only transient.

The second general observation is that with an esophageal diverticulum there may be bizarre behavior of the stomach. The symptoms vary from mere salivation to gross dysphagia and nausea and vomiting. In 1 of our cases the patient was sent in with a clinical diagnosis of ulcer. We concluded that the roentgenograms sent in from a small nearby hospital confirmed this opinion and so stated.

Esophageal symptoms were not referred to. Treatment for ulcer was unsuccessful, and on recheck in our office we observed a diverticulum. We therefore stated that the patient had both esophageal diverticulum and gastric ulcer. The surgeon to whom this patient was referred said, "When we remove the diverticulum, the ulcer will disappear too." Like doubting Thomas, we requested the privilege of a recheck after surgery and seven days after, we rechecked to find all evidence of the ulcer absent, and the patient entirely comfortable and eating all types of food.

The third item is that occasionally a single diverticulum of the colon or a single small cluster of diverticula may cause local tenderness and spasm. These can be missed in the routine examination which shows only the superior and inferior margins of the colon. It is for this reason, among others, that we routinely make a roentgenogram of the colon in what we call the frog or physiologic posture to show the other two margins of the colon in relief. In a few instances we have been able to prove the presence of these diverticula on the posterior or anterior surface, and in 1 case they were demonstrated to be exactly as depicted when cholecystectomy was performed.

The fourth observation is that constant consideration of the possible presence of diaphragmatic hiatal hernia will increase the percentage of diagnoses of diverticula of the upper portion of the stomach. It has been observed that if you can really interest your technician in trying to demonstrate hiatal hernia in every patient, you may see a number of cases of the ordinary reflux which occurs in many elderly persons, but you will also find more evidence of pathologic change in the submitted roentgenograms than you will in the most careful fluoroscopic postural manipulation. Since our interest in hiatal hernia has been enhanced, we have found at least four gastric diverticula, two of which were proved surgically. These are also shown in our slides.

The fifth generalization is illustrated by a case in which a woman was sent in for reported bleeding from the rectum or vagina and a palpable mass discovered in the rectovaginal septum which was thought to be a malignant lesion. The referring physician was so firmly convinced of his diagnosis that he did not consider the diagnosis open to question. It was the patient who so represented the thought of a malignant disease that she requested any further examination indicated. The

peculiar wormlike mass palpated together with a comparative lack of induration of the vaginal wall prompted us to give a barium enema, which enabled us to demonstrate multiple diverticula.

The sixth observation is that although certain sites show diverticula more often than others, they may occur anywhere, and one should not ignore any area as an improbable site. They occur in the ileum and cecum as well as in the sigmoid colon.

The seventh point is that a barium meal will often show diverticula when a barium enema fails.

The eighth and concluding general observation is that it should never be forgotten that degenerative changes may superimpose themselves upon the inflammatory changes of diverticulitis. Because the more benign condition is the more evident, a false sense of security should not be engendered, but due care must be exercised in seeking for evidence of malignant disease when the clinical evidences present themselves.

It may be possible to find all these facts stated in the literature if a careful search be made, but since my attention has been directed to one or all of them in recent discussions of this subject, I concluded that these points, all related to one type of pathology, merit emphasis and enumeration. During the presentation of this paper illustrative slides were shown demonstrating the points emphasized. Since these numbered about forty, it would be impossible to use all these as illustrations.

908 Huntington Building.

Discussion

DR. FREDERICK K. HERPEL, West Palm Beach: Dr. Raap, in the limited time allotted to him, covered well the subject of his paper. All of us who have engaged in the practice of radiology do miss some of these diverticula on the initial examination. I have great confidence in the ability of a well trained technician to demonstrate these lesions, after we have discovered them on fluoroscopic study. For some twelve to fifteen years I have been specifically looking for evidence of hiatal hernia in all patients who undergo roentgen examination of the gastrointestinal tract, and I have been impressed with the number demonstrated. We are indebted to the cardiologists for stimulating us to pay more attention to the esophagus and the junction of the esophagus and stomach.

**The Editor Invites Your Contributions
On Data of Notable Interest**

Toxic Effects of Tetraethylpyrophosphate: Report of a Case

GARLAND M. JOHNSON, M.D.

FORT LAUDERDALE

The importance of familiarity with the new insecticides and their toxic action is illustrated by a case which recently came under my observation. The report of this case follows:

Report of Case

On July 2, 1949, E. C., a 23 year old crop duster, said he had been spraying with tetraethylpyrophosphate (TEPP) and complained that his eyes hurt, the pupils were small and the vision was blurred. He said he did not feel ill otherwise except that he had been tired, felt nervous and restless, and had been unable to sleep. He had experienced no gastrointestinal symptoms and no difficulty in breathing. Because of the ocular discomfort he had been in a hospital in Georgia for a day, where the eyes had been treated with butyn and cold compresses.

On examination, the visual acuity was 20/60 in each eye, but he experienced extreme discomfort on attempting to see the chart. Near vision was Jaeger 1. Miosis was extreme, and tension felt low. A faint conjunctival pinkness was noted, but no ciliary injection. Extraocular motions caused great discomfort, but were normal. The corneas and media were clear; there were no aqueous flare and no cells in the anterior chamber. Because of the extreme miosis I had difficulty seeing the fundus, but I was certain there was no pathologic change there. I was convinced that he had no iritis and no conjunctivitis. He presented the picture of a patient undergoing treatment for glaucoma.

My first thought was to drop atropine in the eyes. Since the vision was already blurred, I hesitated to confuse the picture by an atropine blurr. I reasoned that this must be a systemic rather than local poisoning, since he had been crop-dusting. So I considered giving him atropine intramuscularly or intravenously, but this therapy seemed drastic. Since he only complained of ocular discomfort, I considered dropping homatropine or paredrine in the eyes. I did not know what tetraethylpyrophosphate was, and as he had been riding in a car all night to come down from Georgia and it was then 6:30 a.m., I advised him to go to bed and try to sleep, to call me if the symptoms increased and to let me see him the next morning. That would give me time to find out about the drug with which I was dealing.

On the following morning I was prepared to treat the patient, but by that time the eyes were reported to be normal, and the patient returned to Georgia feeling well.

Discussion

When the Allies entered Germany at the close of the war, they found the Germans had developed a new series of alkyl phosphate insecticides with nicotine-like action. Hexaethyltetraphosphate (HETP) was used under the name of bladon, but tetraethylpyrophosphate is the active ingredient and is used in this country under the name of nifos and vapotone XX.

Tetraethylpyrophosphate ($(C_2H_5)_4P_2O_7$) is a colorless liquid miscible with water, acetone, alcohol, glycerine and propylene glycol. It rapidly becomes unstable in water, but remains stable in lipids. It is hygroscopic and is readily hydrolyzed to inert diethyl acid phosphate. It has a low boiling point, and its low vapor tension makes it suitable for a spray for crop-dusting.

Goodman and Gilman^{1,2} stated:

The parasympathetic or craniosacral outflow consists of three outflows of preganglionic fibers from the central nervous system and their postganglionic connections. The regions of central origin are the midbrain, medulla oblongata and sacral part of the spinal cord. The mid-brain or tectal outflow consists of fibers arising in the Edinger-Westphal nucleus of the third cranial nerves and going to the ciliary ganglion in the orbit. The medullary outflow comprises the parasympathetic components in the seventh, ninth and tenth cranial nerves. The fibers in the facial nerve form the chorda tympani, which innervates the ganglia lying on the submaxillary and sublingual glands. They also form the vidian nerve and innervate the sphenopalatine ganglion. The glossopharyngeal autonomic components innervate the otic ganglion. From these peripheral ganglia, postganglionic parasympathetic fibers originate which supply the sphincter of the iris, the ciliary muscle and salivary, lacrimal and mucous glands. The vagus nerves arise in the medulla and consist of preganglionic fibers which do not synapse until they reach the many small ganglia lying directly on or in the viscera of the thorax and abdomen. The vagus also carries afferent fibers from the viscera into the medulla.

The sacral outflow consists of axones which arise from cells in the second, third and fourth segments of the sacral cord and form the preganglionic fibers to the pelvic nerves. They synapse in terminal ganglia near the bladder, rectum and sexual organs. The vagus and sacral outflows provide motor secretory and vasodilator fibers to all the thoracic, abdominal and pelvic organs.

Loewi in 1921 established chemical mediation of nerve impulses and called the substance vagusstoff, which has been shown to be similar to, if not identical with, acetylcholine. Preganglionic fibers stimulate ganglionic cells through release of acetylcholine at the synapse. Acetylcholine is the chemical mediator released from postganglionic parasympathetic fibers. Acetylcholine exists in the tissues in a form which is physiologically inactive, nondiffusible and susceptible of destruction by cholinesterase. A nerve impulse changes the acetylcholine from inactive to active diffusible form,

which is then hydrolyzed by cholinesterase to the inactive form of choline and acetic acid.

Cholinesterase is a ferment which is found in the plasma and in the erythrocytes and is present in tissues, especially where acetylcholine is liberated. The enzyme is present in all nerve fibers, but is concentrated at the synaptic regions and localized at the neuronal surface. Tetraethylpyrophosphate is an anticholinesterase like diisopropyl fluorophosphate (DFP). It irreversibly destroys cholinesterase as does DFP. Eserine and prostigmine inhibit cholinesterase temporarily. Thus if DFP or TEPP is given followed by eserine or prostigmine, the action is potentiated. If eserine or prostigmine has been given and is followed by DFP or TEPP, the action of the latter is inhibited because the cholinesterase is temporarily inactivated and cannot be destroyed by DFP or TEPP; so their action is rendered ineffective.

Tetraethylpyrophosphate is similar to diisopropyl fluorophosphate, which has been used in the treatment of glaucoma. Cogan, Dunphy and Grant³ used TEPP in a series of cases of glaucoma and found it satisfactory, resulting in miosis and lowering of intraocular tension. They concluded that it has no advantages over DFP since the duration of action of DFP is seven days or more and of TEPP twenty-four to forty-eight hours. Both drugs cause ciliary spasm, of which my patient complained with lens fixed for near vision (false myopia). DFP, used in less frequent dosage than pilocarpine or eserine and effective when these drugs fail, appears to be the drug of choice for aphakia.

TEPP appears to be the drug of choice in the treatment of myasthenia gravis. This disease, the cause of which is unknown, is due to alteration in physical chemical changes that initiate muscular contraction. The acetylcholine is prevented from exerting its normal effect. This result could occur because of a decrease in the amount of acetylcholine, or an increase in the cholinesterase. It may be due to inadequate synthesis of acetylcholine or antagonistic curare-like substance. Prostigmine combines with and inactivates cholinesterase and has lengthened the life of the myasthenia gravis patient and made him useful. But the effect of prostigmine lasts one to several hours, and symptoms of weakness and difficulty in breathing and swallowing recur usually before the next dosage is administered. Tetraethylpyrophosphate can be given in doses of 8 to 15 mg. daily in two or three divided doses, and relief of symptoms is better sus-

tained than with prostigmine. The therapeutic dose and toxic amounts are within a narrow range, 0.5 to 3.0 mg., and the patient must be watched and regulated like the diabetic patient.

Tetraethylpyrophosphate is readily absorbed through the skin, through the mucous membranes of the conjunctiva and intestinal tract, or by inhalation. Therapeutically, it can be taken by mouth as a 2 to 5 per cent solution in propylene glycol. This solution is dissolved in water, but must be swallowed immediately as it rapidly hydrolyzes. It may be given by intramuscular injection in a 5 per cent solution in propylene glycol. Tetraethylpyrophosphate is powerful and dangerous and highly toxic to warm-blooded animals. The toxic symptoms are miosis, lowering of intraocular tension, ciliary muscle spasm with spasm of accommodation with the lens fixed for near vision, striated muscle fasciculations, increased gastrointestinal tone with abdominal cramps, diarrhea, nausea, vomiting, perspiration, lacrimation, salivation, restlessness, bradycardia, cardiospasm, complete auriculoventricular dissociation, constriction of bronchial muscles, increased secretion of bronchial glands, and convulsive seizures that may be epileptiform. The antidote is atropine, dropped in the eye for miosis or given intravenously for severe systemic poisoning, 0.6 mg. to be repeated up to 2.0 mg. until dilatation of the pupil takes place. Immediate action should be taken in the treatment of the severe systemic poisoning because death can occur rapidly, usually from the bronchial constriction (asthma) but also from central stimulation followed by depression, or from stimulation followed by depression of striate muscles or from excessive stimulation of autonomic effector cells.

The mechanism of death from Jamaica ginger poisoning in the prohibition era is the same as the causes of death owing to tetraethylpyrophosphate. The first effect on striate muscles is fasciculations of the tongue, which spread to other muscles. Muscle weakness in the legs may be followed by paralysis. This muscle weakness may persist after other functions have returned. If death does not occur in twenty-four hours, the patient will likely recover.

The United States Department of Agriculture reports TEPP to be effective against aphids, mites, leaf hoppers, thrips and caterpillars. It rapidly loses its toxicity on standing in the presence of moisture; so it must be mixed fresh before using. TEPP has been applied to 133 plant species

with injury only to certain species of chrysanthemums and tomatoes, in which it causes spotting of the leaves. This is almost eliminated if the temperature is 70° to 74° F.

Summary

A case is reported describing the toxic effect of tetraethylpyrophosphate (TEPP) on the eyes. The drug and its actions are discussed.

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Discussion

DR. HOWARD V. WEEMS, Sebring: It is most fitting that a paper should be presented at this time on this subject; this agent, best known as Parathion, is used on apples, pears, peaches, plums, grapes, ornamental shrubbery and nursery stock, carrots, celery, peppers, potatoes, tomatoes and, most important of all to the South, citrus and tobacco. A number of cases of poisoning and a few deaths have been reported among persons using parathion as a spray. The packages come with a label telling of the dangers and urging great care in its use. The label also tells that atropine is the chief drug used in the treatment should poisoning occur. Oxygen is also of value, but atropine is given in doses of 1/60 of a grain and may be repeated in this dosage every hour for several doses.

On Aug. 23, 1949, I treated a man for poisoning, who recovered in less than one day. The same man was treated for the same cause on September 17. At this time he died within a few hours in spite of strenuous treatment.

I would urge that all physicians familiarize themselves with this product, parathion, and with the treatment for poisoning by it.

DR. WILSON T. SOWDER, Jacksonville: Doctor Johnson's paper is timely. Only a few days ago, Mr. Frank Holland, representing the Agricultural Research Institute of Lakeland, called on me at the State Board of Health. He said that all the agencies concerned with agriculture including insecticide manufacturers and distributors are anxious that the latest information about the newer chemical insecticides be brought to the attention of the physicians of the state as rapidly as possible.

Since the discovery of DDT, a great many new insecticides have been put on the market and some of these are exceptionally efficient in their action on insect pests. Unfortunately, the ones that are most effective also are highly poisonous to humans if they are not used with proper precautions, and some deaths have occurred from their use. He said that there was little hope that the use of such insecticides would be discontinued because of these dangers, since they are important to agriculture. In one instance at least they have saved a whole industry, the tobacco industry, from ruin. He said it is the opinion of the agricultural interest that there is no more logic in stopping the use of such poisons because of their dangers to humans than there would be in stopping the use of gas or electricity for heating purposes because deaths from their misuse occasionally occur. He was most anxious to secure the cooperation of the medical profession in disseminating information as to the precautions necessary and also the first aid treatment procedures indicated in the case of poisoning.

It is my understanding that one of the most useful and efficient insecticides now in use is parathion. The first aid treatment for poisoning by this agent consists in the injection of atropine and in some cases administration of oxygen. The State Board of Health is attempting to disseminate information about these insecticides. I should like to urge physicians practicing in agricultural areas to familiarize themselves with the insecticides being used in their area.

Mr. Holland can be of assistance to these physicians in getting the latest information from the manufacturers as to the chemical makeup of these agents, and as to their pharmacology and toxicology. The State Board of Health also has a great deal of information on this subject which we will be glad to send to anyone who is interested.

DR. JOHNSON, concluding: I wish to thank Dr. Sowder and Dr. Weems for their discussion. It is certainly important for the doctors to be familiar with the new insecticides, because immediate treatment may save a life. In the case of my patient, the action of the drug was gone by the next morning and no treatment was given. If I had known the actions of tetraethylpyrophosphate I could have given him immediate relief from the ocular symptoms.

The Scientific Department of The Journal

Reflects the Experience of You
and Your Colleagues

Clinical Application of Electrocardiography

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MIAMI BEACH

The wide publicity which is being given to organic heart disease in the press and popular magazines has undoubtedly served a useful purpose in bringing many potential cardiac patients under proper management by their physicians. Many of the patients will have no clinical or laboratory evidences of organic heart disease. Others will give a doubtful history of a possible myocardial infarction, with physical findings which may be suggestive of this condition. In this group, the interpretation of the electrocardiogram will usually be the deciding factor in making a diagnosis. In view of the major role of the interpretation of the electrocardiogram in determining whether the patient may continue his normal activities, or be under the severe physical restrictions entailed in the management of such a disease, it is imperative that the examining physician have a sound and basic knowledge of what constitutes unequivocal electrocardiographic evidence of myocardial infarction.

It is extremely important that such a diagnosis in doubtful cases should not be made on one tracing which may show only slight T wave inversion, minimal displacement of the RS-T segment, and slurring of the QRS complexes. In these cases there should be further clinical and electrocardiographic studies, until a definite decision can be made. To ignore this precaution is to create cardiac neurotics of healthy persons. This also applies in a large measure to other electrocardiographic abnormalities when an electrocardiographic diagnosis is substituted for a clinical diagnosis of the underlying pathologic process responsible for the electrocardiographic findings. As an aid to avoiding some of the pitfalls in electrocardiographic interpretation, as practiced by the clinician, a short review of the subject is presented, with a brief explanation of the basic reasons involved.

In 1929 Dr. Frank N. Wilson began to use the multiple precordial leads. Since that time he and his associates,¹⁻⁴ as well as many other investigators, have repeatedly demonstrated the clinical

value of the multiple precordial leads and the unipolar limb leads, utilizing the central terminal as the indifferent electrode. Methods of investigation, the facts obtained, and the conclusions drawn are all set forth in scientifically detailed articles on the subject by the investigators mentioned. The use of the multiple precordial leads and the unipolar limb leads as advocated by Wilson and his associates is especially valuable in cases of bundle branch block, ventricular hypertrophy and myocardial infarctions. It is particularly in these conditions that the standard limb leads have proved inadequate. The purpose of this article is again to direct attention to the additional information that may be obtained by the use of the unipolar limb leads and the Wilson precordial leads in comparison with that gained from the use of the standard limb leads only. While it is understood that a basic knowledge of electrocardiography is essential for its proper understanding, an attempt to simplify the explanations will be made without reference to the more involved principles, laws and experimental proofs of statements made. This attempt to simplify the discussion is in no way to be interpreted as overlooking the value of the highly scientific investigator's work, but rather to stimulate more widespread clinical use of these important findings.

To fail to make use of the detailed electrocardiographic information by the procedure herein advised is to neglect a valuable aid in obtaining the full value in electrocardiography. Today, approximately eight years have passed since this information has been made available for clinical use. Yet, many competent physicians interested in cardiology have neglected to use these new methods, as advocated by the American Heart Association, and continue to use only two or three precordial leads, and to substitute the left foot as the indifferent electrode, completely ignoring the value of the central terminal. It is difficult to understand how some otherwise intelligent cardiologists should persist in using the single precordial lead and calling it lead IV, as though it were com-

parable in all respects to the standard limb leads. The use of leads CF_4 , CF_5 , and CF_2 , while helpful in many cases, actually gives far less information than the recommended six precordial leads which allow adequate comparison of the potential variations between the right and left side of the heart. Use of the central terminal enables the indifferent electrode to be very close to zero potential as it acts as an artificial ground. The term "unipolar" is used to designate leads of this kind in which one electrode is almost completely indifferent, and the term "bipolar" to designate leads like the standard limb leads in which the two electrodes are approximately equidistant from the heart and can be expected to undergo potential variations of about equal magnitude. The use of the foot as the indifferent electrode, as in CF leads, is much less accurate as the foot has its own potential variations, which are derived from the heart and which obscure the potential variations recorded by the exploring electrode. Use of the central terminal, then, enables the exploring electrode to record the potential variations of the underlying heart muscle without any significant interference from the indifferent electrode.

The standard limb leads and unipolar limb leads are directly related. The relationships have been expressed in mathematical equations.^{5a} It is readily recognized, however, that VL minus VR equals lead I; that VF minus VR equals lead II; that VF minus VL equals lead III. Thus, in considering unipolar limb leads and the standard leads, if one has the values for any of the two leads, he can easily compute the remaining four. Unipolar limb leads from the right arm, the left arm and the left leg reflect the potential variations of that particular surface of the heart which faces that particular extremity. This transmission of potential variation from the epicardial surface towards a particular extremity depends in turn upon the position of the heart in the chest. The potential variations of the right arm are normally of the same general nature, that is, conspicuously negative during the greater part of the QRS interval. Minor variations of a slight positive deflection at the beginning or end, or both at the beginning and the end, are, however, occasionally encountered. The clinical significance of these minor variations which occur in a normal heart has been explained by Myers and Klein⁶ and Goldberger⁷ as due to the rotation of the heart about its various axes.

Goldberger⁷ modified the original Wilson method of obtaining unipolar limb leads by removing the connection of the limb to which the exploring electrode is attached from the central terminal. The tracings obtained by the Goldberger method are identical with those obtained by the Wilson method, except for a 50 per cent increase in voltage in the former method. Use of the Wilson method by increasing the sensitivity of the string gives tracings identical in contour and voltage to those of the Goldberger method. The explanation given for this negative potential in the right arm lead is that it is due to a referral of the negative potential of the endocardial surface of the heart through the openings in the heart which admit the great vessels and face toward the right shoulder. Variations in potential in the left arm and left leg change with the position of the electrical axis of the heart. When the left ventricle faces toward the left shoulder, the greater electrical effect in activation of the heart muscle from endocardial to epicardial surfaces is toward the left shoulder, and positive potential of the left shoulder results. Similarly, when the left ventricle faces toward the left foot, a markedly positive potential will be recorded in the foot under normal circumstances. Thus, when the left epicardial surface of the left ventricle faces toward the left shoulder, VL is similar to V_6 and lead I. The heart is therefore in a horizontal position. Similarly, if the epicardial surface of the left ventricle faces toward the left leg, then VF resembles V_3 and lead III, and the position of the heart is vertical. Wilson and his associates introduced this method of determining the electrocardiographic position of the heart, depending upon the degree of rotation around its anteroposterior axis, describing six positions ranging from a horizontal to a vertical position. The electrocardiographic position of the heart is determined by the spacial relations of the two ventricles, their muscle masses and order of depolarization and repolarization in regard to the three limbs concerned. In a normal heart, the precordial electrocardiogram has essentially the same form regardless of the electrocardiographic position of the heart.

It is well known that activation of the heart normally occurs from the endocardial surface to the epicardial surface. The activation is immediately preceded by a wave of positive potential and leaves in its wake a negative potential. The potential variation of every part of the heart muscle

during activation acts in various directions simultaneously and contributes, in some measure, to the potential variations of an electrode placed on the precordium. The magnitude of the potential variation of the electrode is, however, great if its distance from the epicardial surface is small, and vice versa. Because of this fact, the precordial electrode is able to record the potential variations of the underlying ventricular surface which lies nearest the electrode. This makes it possible, by moving the electrode across various set points of the precordium, to determine the nature of the potential variations across the anterior surface of the ventricles. In order that the exploring electrode may record them accurately, however, there must be no interference from the indifferent electrode. To accomplish this, the central terminal is used, rather than the foot or some other point of the body surface.

The intrinsicoid deflection is the name given to the abrupt deflection of the tracing in the precordial electrocardiogram, which coincides with the activation of the heart muscle directly beneath the exploring electrode. The intrinsicoid deflection is easily identified in precordial leads. It begins at the peak of R as a sudden downward deflection and ends at the nadir of S. For clinical purpose, one may consider the peak of R as coinciding with the time of activation of the epicardial surface just beneath the exploring electrode. Actually, the end of the intrinsic deflection at the nadir of S coincides with the excitation of the subepicardial muscles.⁹ It is readily recognized then that the QRS interval is divided into two phases by the intrinsicoid deflection. That part of the QRS phase which precedes the intrinsicoid deflection is attributed to cardiac muscle which entered activation before the subepicardial muscle under the exploring electrode, and that phase of the QRS complex which follows the intrinsicoid deflection must have been activated after the subepicardial muscle. Normally, the intrinsicoid deflection occurs earlier in the QRS interval in leads over the right ventricle, and later in leads over the left ventricle. This difference is attributable to the greater thickness of the left ventricular wall.

Normal conduction pathways are from the sinus node through auricular musculature to the AV node, then to the left and right bundle, and through the Purkinje fibers spread out in the subendocardial surfaces of the ventricles. It has been shown that the left side of the septum is activated

slightly before the right side.⁹⁻¹¹ This difference is thought to be due to a small branch arising high from the left bundle. The slightly earlier activation of the left side of the septum results in an initial positivity of the subendocardial muscle in the right ventricle, as this muscle lies directly in front of the wave of positivity which always precedes activated cardiac muscle. A very short time later the septum becomes activated simultaneously from both sides, and these electric potentials tend to neutralize each other, as they are acting in opposite directions and are of approximately equal intensities. From this time on, cavities of both ventricles manifest a negative potential throughout the rest of the QRS phase, as the cardiac impulse is spreading away from the ventricular cavity; and hence they are continuously on the negative side of the boundary between the active and resting muscles.

Bundle Branch Block

Bundle branch block, whether right or left, can readily be identified by determining from the intrinsicoid deflection the time of arrival in the QRS interval of activation of the subepicardial layer of muscle lying beneath the exploring electrode.^{7b, 12} While a person with bundle branch block, without other signs or symptoms of heart disease, may have the same life expectancy as a similar person of the same age, it still is important clinically to determine which type of bundle branch block exists. Although both right and left bundle branch block occur in about equal frequency in some types of heart disease, right bundle branch block is much commoner in myocardial infarctions, Chagas' disease, congenital heart disease and especially in pulmonary embolism. In the last named disease, left bundle branch block is rarely, if ever, encountered. The diagnosis of bundle branch block of course necessitates demonstrating a normal conduction pathway up to the point of block and an increased QRS phase to 0.12 seconds or more in a complete block.

Left Bundle Branch Block

The diagnosis of left bundle branch block can be made when the following criteria can be demonstrated:

PRECORDIAL LEADS.—1. Late intrinsicoid deflections are present in V_6 or leads taken to the left of V_6 . These leads usually show a broad-topped or bifid R wave. The intrinsicoid deflection in lead V_5 or V_6 is identified as the downward deflection at the peak of R or R', if the latter is

present, because the subepicardial surface lying beneath these leads is activated last. The leads usually are broad-topped or show a bifid R, because of the abnormal path, and indicate two components: activation of the septum from right to left and activation of the free wall of the left ventricle from within outward.

2. No Q waves are present in leads from points to the left of the transitional zone, as the cavity of the left ventricle is initially positive. The transitional zone may be defined as the point on the precordium where the R wave becomes of greater magnitude than the S wave in the preceding lead. (Exception: when left bundle branch block is complicated by a transseptal infarction, as this may prevent the cavity of the left ventricle from becoming initially positive in the QRS phase.)

3. In leads from the right of the transitional zone, the final QRS complex is downward and broad. This configuration is due to the negative potential from activation away from the cavity of the overlying electrode, as the septum is activated from right to left, plus the continued direction of electric force from right to left as it passes through the thick lateral wall of the left ventricle. This negative deflection is more frequently preceded by a very small and narrow R, which probably represents early activation of the wall of the right ventricle.

4. The transitional zone, while subject to many normal variations, is usually between V_2 and V_3 , and as a rule is displaced further to the left in this condition.

5. The T wave in V_5 or V_6 is inverted.

6. The ST segment in V_1 or V_2 may be elevated and in V_5 or V_6 depressed.

UNIPOLAR LIMB LEADS.—1. Unipolar limb leads in left bundle branch block are variable, and dependent upon the electrocardiographic position of the heart.

2. In a horizontal or semihorizontal position, the QRS complexes of VL resemble lead I and V_6 .

3. In a vertical position, which is rarely present in left bundle branch block, VL and lead I are similar to V_1 or V_2 . In this case, from the standard limb leads alone, a diagnosis of right bundle branch block would inevitably be made.

4. In a semivertical position, VF would resemble lead I and V_6 .

STANDARD LIMB LEADS.—Standard limb leads in left bundle branch block usually show a broad monophasic R in lead I, and usually a left axis

deviation. The QRS complexes in lead I may vary considerably, owing to the electrocardiographic position of the heart, which makes standard leads alone unreliable for detection of the location of the bundle branch block.

INCOMPLETE LEFT BUNDLE BRANCH BLOCK.—When left bundle branch block is incomplete, it may be particularly difficult to distinguish from left ventricular hypertrophy, and the two conditions frequently coexist. In order to make a diagnosis, there must be normal conduction through the auricular muscle and AV node, and a prolonged QRS complex between 0.09 and 0.11 seconds. The precordial leads are similar in left ventricular hypertrophy and incomplete left bundle branch block, with regard to the late occurrence of the intrinsicoid deflection in the QRS phase in V_5 and V_6 .

The prolongation of the QRS complex is usually less in left ventricular hypertrophy than in incomplete left bundle branch block. The late intrinsicoid deflection in V_6 is due to the abnormal pathway in the latter condition.

If a Q wave is present in leads over the left side of the precordium (V_5 and V_6), as may occur in left ventricular hypertrophy, then incomplete left bundle branch block may be excluded. A Q wave in these leads, however, does not always occur in left ventricular hypertrophy.

Earlier activation of the septum from the right side, in incomplete bundle branch block, would prevent the occurrence of a Q wave in V_6 , as the left ventricular cavity would be initially positive.

Right Bundle Branch Block

In right bundle branch block, the precordial leads are approximately opposite in configuration to those observed in left bundle branch block.

PRECORDIAL LEADS.—1. Leads from the right side of the precordium usually display a small initial R followed by an R'. The R represents the activation of the septum from left to right, and the R' represents activation of the wall of the right ventricle from within outward. The peak of R' then indicates the intrinsicoid deflection, and it falls late in the QRS interval. There may also occur a broad monophasic R deflection due to fusion of the septal and free wall of the ventricle components with notching.

2. As the precordial leads are moved towards the left precordium, the initial R increases in magnitude, and finally becomes a tall thin R wave

which may or may not be preceded by a small Q wave. The small Q wave, which may occur in V_6 , is thought to be due to early septal activation from left to right. The second component or R' deflection diminishes rapidly in size, and finally becomes a broad and shallow S in V_6 .

3. The broad but shallow S in V_6 indicates activation of cardiac muscle is still occurring in another part of the heart, after activation of the cardiac muscle beneath the exploring electrode. This S then is a reflection of the negativity of the ventricular cavity, due to late activation of the free wall of the right ventricle. The early R in V_6 indicates that no delay exists in transmission through the left bundle branch.

4. The transition zone in right bundle branch block is usually shifted to the right, between V_1 and V_2 .

5. V_1 usually shows an inverted T wave.

UNIPOLAR LIMB LEADS.—These leads show, as a rule, the VL lead similar to lead I, and a conspicuous S wave. The VR lead usually shows a late broad R.

In many cases of an increased QRS interval to 0.12 seconds or more, the precordial leads may show only part of the typical characteristics of either right or left bundle branch block, and cause uncertainty as to the location of the conduction defect. This condition may be brought about because of many reasons. In those cases in which the ventricular complexes of the same general type in all six precordial leads occur and no transitional zone is identified, it may be well to take additional leads to the right if a lesion in the right bundle branch is suspected, or additional leads to the left, if the left bundle branch is under suspicion. This procedure would enable one to identify the transitional zone and to compare the potential variations of the anterior surface of the right ventricle with the potential variations of the anterior surface of the left ventricle.

INCOMPLETE RIGHT BUNDLE BRANCH BLOCK.—This disease can be diagnosed more easily in unipolar precordial leads than can incomplete left bundle branch block. Unipolar precordial leads are by far the most satisfactory means of diagnosing incomplete right bundle branch block. The QRS complexes show a delay between 0.08 and 0.11 seconds, and the early and small R and the late R' in V_1 , V_2 , or VE are similar to those of complete right bundle branch block, as is the broad S in V_6 . An additional lead to the right of V_1 is, however, frequently helpful, demonstrating

more clearly the delayed intrinsicoid deflection from the right ventricle.

In the unipolar limb leads, the configuration of VR as a rule shows a late, broad R. The standard leads are rarely diagnostic of incomplete right bundle branch block.

Ventricular Hypertrophy

It is recognized that the QRS complexes in V_1 and V_2 are derived mainly from the potential variations of the right ventricle and those QRS complexes in V_5 and V_6 are derived mainly from the underlying left ventricle.

That the right ventricle has a thinner wall than the left ventricle accounts for the small R in V_1 and V_2 and the larger R in V_5 and V_6 . It is understandable then that in predominant hypertrophy of the left ventricle these normal differences in the QRS complexes will be exaggerated. That is, the R in V_1 and V_2 will be smaller, and the R in V_5 and V_6 will be larger. In right ventricular hypertrophy these normal differences will be decreased; the R in leads over the right side of the heart is taller than normal and over the left side of the heart the R is smaller. From these considerations little can be expected from the precordial leads when the increase in the masses of the two ventricles is relatively proportional.

Left Ventricular Hypertrophy

Preponderant left ventricular hypertrophy usually may be expected to show the following electrocardiographic characteristics:

1. V_1 and V_2 will show a very small R or even a QR deflection. The S or QS deflection is usually deep and broad, indicating late activity of the left ventricle and slightly increased duration in traveling a longer path through the thickened left ventricular wall.

2. The transitional zone is displaced further to the left (V_3 or V_4).

3. V_5 and V_6 show an abnormally large R, with the peak of R (the beginning of the intrinsic deflection) occurring slightly later in the QRS complexes than would normally be present. A small Q wave precedes the R in approximately 50 per cent of the cases.

4. The QRS complex is frequently increased to 0.10 seconds.

5. The T wave in lead V_4 , V_5 or V_6 is often inverted.

6. The RS-T segment may be depressed in V_6 .
STANDARD LIMB LEADS.—Usually the standard limb leads show left axis deviation if the heart is

in the horizontal or semihorizontal electrocardiographic position. Absence of axis deviation with large R deflections may be present when the heart is in the semivertical position. Rarely, right axis deviation occurs in vertical hearts with predominant left ventricular hypertrophy.

UNIPOLAR LIMB LEADS.—These leads will show high voltage in lead VL, similar to lead I, if the heart is in a horizontal position. If the heart is vertical, similar findings are noted in VF, which is similar to standard leads II and III.

Right Ventricular Hypertrophy

Predominant right ventricular hypertrophy may be expected to show the following electrocardiographic findings:

PRECORDIAL LEADS.—In general, precordial leads show opposite findings to those of left ventricular hypertrophy.

1. Abnormally large R waves, frequently preceded by a small Q wave and followed by inverted T waves are present in leads over the right precordium (V_1 , VE and at times V_2).

2. In leads over the left precordium (V_5 and V_6) the R wave is small and occurs early in the QRS interval. There is no Q wave, but a relatively deep S wave is commonly noted. There tends to be a diminution in the size of the R wave in passing from the right to the left precordium.

3. The transitional zone may be shifted somewhat to the right.

STANDARD LIMB LEADS.—As a rule the standard limb leads show right axis deviation, but variations in this finding are common and depend on the electrocardiographic position of the heart. If the heart is in the semivertical position, large S waves are present in all the standard leads.

Myocardial Infarction

Animal experimentation has shown that gradual diminution of the lumen of a coronary artery is first manifested by a deep sharply inverted T wave, when unipolar direct leads are taken over the affected surface of the ventricle. Rapid retrogression occurs when the normal circulation is soon re-established. A more severe grade of myocardial ischemia results in an upward displacement of the RS-T segment and junction, and is of a reversible nature if the ischemia is of short duration. When the obstruction is sufficient to cause death of an area of cardiac muscle, a prominent Q wave results.¹² The Q wave represents a transmission of the initial negativity of the underlying ven-

tricular cavity to the epicardial surface. If the whole thickness of the ventricular wall which lies beneath the electrode is involved, then a QS deflection may be expected; the dead muscle is incapable of responding to the excitatory impulse, but is capable of transmission of the potential of the underlying ventricular cavity, which normally remains negative through the QRS interval (exceptions as described for initial positivity of the right ventricular cavity). If the infarcted muscle is not completely transmural, as occurs in many cases, and some part of the muscle remains viable, then a small embryonic R wave may be seen as an upward notch on the descending or ascending limb of the monophasic QRS component. If remaining living muscle is subepicardial, a true R may be seen to rise above the base line, and results in a large Q followed by a small R and possibly an S deflection. One would expect to observe this type of deflection at the margins of the infarcted area. A sharply inverted T wave may also be present in these zones, because of the ischemia of this epicardial layer which increases the duration of its systole. The findings in the unipolar leads from the precordial leads are similar in form to those changes already described for direct leads from the epicardial surface.

In the human, the earliest change to occur consists of RS-T displacement. The infarcted areas are usually more extensive in the subendocardial area than in the subepicardial side. A thin layer of muscle beneath the endocardium, however, usually survives, possibly because of direct diffusion of oxygen from the ventricular cavity, the collateral flow through the thebesian veins and the rich arteriolar anastomosis of the subendocardial plexus. This thin layer of uninjured muscle may account for the more common upward displacement of the RS-T segment. Animal experimentation shows that a downward RS-T segment displacement would be expected when there is more extensive damage in the subendocardial area than in the subepicardial area.

Bayley¹⁴ believed downward displacement of the RS-T segment may be due to vascular spasm of the subendocardial plexus. The RS-T segment tends to return to normal, but may persist a variable time from hours to weeks. Its tendency to regress may be taken as a favorable sign of recovery, and a prolonged RS-T displacement in myocardial infarction is considered unfavorable.

If the displacement becomes more pronounced, or returns after regression has occurred, it may be

considered on the basis of a pericarditis or extension of the infarcted area. If it is caused by the latter, then further changes in the Q waves may be expected in a larger number of precordial leads, if the infarction is anterior.

The Q waves present in anterior infarctions may also occur early. They are usually permanent, though they do show regressive changes at a later date, as a rule.

Changes in the T wave consist in a terminal inversion, which may take two to three weeks to develop fully. The inversion of the T may occur at the same time as the QRS changes, may have a tendency to regress slowly, and may or may not disappear completely.

In the posterior type of myocardial infarction there is usually a downward displacement of the RS-T segment for reasons previously described in unipolar precordial leads. In this type of infarction involving the posterior wall, the precordial leads have not the diagnostic value as in the anterior lesions. Esophageal leads, however, are of definite value. Along with the downward displacement of the RS-T segment, the precordial leads may show abnormally large R and T waves. The abnormally large R wave may be explained by the absence of electric forces acting opposite to those passing through the anterior wall of the ventricle; the lack of effect of the former augments the effect of the latter.

It has been shown that the potential variations of the epicardial surface are transmitted to adjacent parts of the body facing this surface. This observation also applies to infarcted regions of the heart. In infarctions of the anterior wall of the left ventricle there is transmission to the precordium; infarctions of the anterolateral wall are transmitted, in addition, to the left arm. In infarctions of the posterior wall, transmission is usually to the left leg as the posterior wall lies on the diaphragm and faces that extremity. There is, however, also transmission to the back and the ventricular levels of the esophagus. The findings of a definite Q wave in VL may reflect the myocardial infarction when it is located in the anterolateral wall of the left ventricle, and similar changes in lead I. A Q wave in VF may reflect a posterior myocardial infarction, and also be in leads II and III. If the infarction is high on the posterior wall, no significant changes may occur in VF. To locate accurately the infarcted area, it is obvious that other leads may be necessary in addition to the six precordial leads.

Bundle Branch Block in the Presence of Myocardial Infarction

In precordial leads it has been shown that the electrocardiographic changes in bundle branch block are due mainly to changes in the potential of the ventricular cavities early in the QRS phase, as well as to delayed activation of the wall of the ventricle, as represented by the late intrinsicoid deflection. In uncomplicated right bundle branch block, the cavity of the right ventricle shows an initial positivity, which is greater and more lasting than normal. In uncomplicated left bundle branch block, the normal, short, initial positivity of the right ventricular cavity is not present, and there occurs a definite, initial positivity in the left ventricular cavity.

It has also been demonstrated that the electrocardiographic changes in uncomplicated anterior myocardial infarction are due mainly to involvement of the wall of the left ventricle or septum. In the precordial leads this change is represented chiefly by an initial negative deflection, the Q wave, which represents the transmitted early negativity of the cavity through the infarcted area.

In left bundle branch block with myocardial infarction, not involving the septum, the cavity of the left ventricle remains initially positive in the QRS phase. This positivity is transmitted through the infarcted area to the epicardial surface. Thus, precordial leads in anterior myocardial infarction, complicated by a true left bundle branch block, cannot result in a Q wave, and such leads are of little diagnostic value in this condition.

In transseptal infarctions when left bundle branch block is present, the precordial leads may show a large QS deflection, as the potential variation of the left ventricular cavity would not be significantly altered. The QS waves in leads over the right ventricle in a condition of left bundle branch block, plus infarction of the wall of the right ventricle, would be expected; and this type of deflection is common in these leads in uncomplicated left bundle branch block; hence they are of little diagnostic value for the presence of infarction.

In right bundle branch block complicated by anterior myocardial infarction, V_1 and V_2 usually show an absence of the initial small R. There is a definite Q, followed by a tall R, which occurs late in the QRS phase. The Q represents the negativity of the left ventricular cavity, which is transmitted by the infarcted area to the epicardial surface. The tall R is due to delayed activation

of the wall of the right ventricle. The Q wave also occurs at points further to the left. The standard limb leads rarely show changes diagnostic of infarction.

In posterior infarction plus right bundle branch block, the precordial leads are not diagnostic of infarction, as they are similar to those of uncomplicated right bundle branch block. The standard leads II and III and lead VF show a definite Q wave in most instances.

Summary

Electrocardiography, when properly understood, can be utilized by the clinician as one of the most accurate of the many diagnostic methods. Its misuse can cause a great source of error and confusion. It should be emphasized that electrocardiographic abnormalities are not diseases. The intelligent use of the electrocardiogram requires its proper interpretation in conjunction with a careful history, physical examination and fluoroscopic studies, in order to determine the underlying pathologic process which is to be treated.

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Reliability of Serologic Examinations As Performed in Medical Laboratories in Florida

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The national serologic evaluation is an annual event. Each spring some 300 to 400 blood specimens collected from normal and known syphilitic donors are distributed to all state laboratories by the Venereal Disease Research Laboratory of the Public Health Service. The same specimens are examined in "control laboratories" by author serologists, for example, by Dr. Reuben Kahn in Ann Arbor, Mich. The findings are assembled, multigraphed and sent to all participating laboratories. Each can measure its own reliability by comparison of findings with those of the control

laboratory; also, the relative reliability of each test is indicated by a comparison of serologic and clinical findings. These evaluations have had a major role in progressively improving the quality of serologic work in state laboratories. The privilege of participating is limited to one laboratory per state; in Florida, this is the Jacksonville laboratory of the State Board of Health. Its performance has placed it consistently among the best of the forty-eight state laboratories.

More than 100 laboratories in Florida perform serologic examinations. Within the past year it

became practicable to make available to these, on a wholly voluntary basis, the stimulating experience of serologic evaluations. In part, this was meeting an obligation, since the laws relative to premarital and prepartum serologic tests require that the State Board of Health approve laboratories for the performance of these tests. The only reasonable basis for this approval is an adequate measurement of quality of performance.

The following evaluation procedures were employed. Blood from serologically similar cases, or serum from identical pools, was submitted to participating laboratories for examination. The specimens were sent in lots of ten or twelve at one time. Identical specimens were submitted to Dr. Kahn and to the Venereal Disease Research Laboratory of the Public Health Service, and a set was retained for the Board of Health laboratory in Jacksonville. These three were the "control laboratories." All findings by control and participating laboratories were reported to the Bureau of Laboratories in Jacksonville. The comparability of test results was measured by a scoring schedule. Full scores indicated agreement with the control laboratories; the lower the score, the wider the divergence from this. On each specimen examined the participating laboratory received a full record of the serologic findings by the control laboratories, plus a brief clinical note on the donor whose specimen was tested. These were attached to a scored copy of the laboratories own finding. Thus agreements and degrees of divergence were clearly evident. The total scores provided a measure of relative reliability of performances.

Specimens were distributed in three series, in November, in January and in May. The maximum number of specimens per series was 48. The findings for each laboratory in each series and by each test procedure were evaluated. Some laboratories entered the evaluation late and therefore examined only their first or first two series. The test most commonly employed was the Kahn, followed by the Mazzini, V.D.R.L., Eagle, Kline and Kolmer tests. The most recently described test, the V.D.R.L., (V. D. Research Laboratory), in which antigen containing cardiolipin is used, gave highly satisfactory results and is being adopted by an increasing number of laboratories. With multiple tests performed in several laboratories, a total of 152 test results was reported by the 105 laboratories which examined at least one series of specimens. Among these 105 laboratories were six regional State Board of Health laboratories and

eight operated by the Army, Navy or Veterans Administration. Fewer laboratories examined the second and third series with a corresponding reduction in test results reported as shown in table 1.

The quality of serologic performance was classified according to scores attained as excellent (score percentage 90 or more), satisfactory (score 80 to 89) and poor to highly unreliable (scores from 79 to as low as 47). The first series revealed the general pre-evaluation quality of serologic examinations (table 1). The findings were almost equally divided, one third excellent, one third satisfactory and the remainder poor to highly unreliable. There was moderate improvement in the results of the second series and decided improvement in the third. In the latter, two thirds of the findings were "excellent," while the number with poor to unreliable test results had declined to 6 per cent.

The major factor in attaining the degree of improvement indicated was the stimulus provided by the evaluations. There was, however, a concurrent series of conferences on serology with guest teachers provided through the United States Public Health Service. The needs emphasized were for an antigen of a proper level of sensitivity, for exact adherence to described technics and judgment acquired through experience in reading test results. Copies of standard test procedures were provided to all laboratories. Furthermore, the assistance of Miss Carolyn Roth, Chief Serologist, Board of Health, was made available to help in detecting and correcting defects in participating laboratories which requested aid. Some laboratories decided spontaneously to discontinue serologic examinations, since their evaluation results revealed performance less than satisfactory. The experience to date indicates that, guided by serologic evaluations, laboratories desiring to do so can perform satisfactory to excellent serologic tests.

This program of evaluation, instruction and consultation is to be continued. With such great improvement in performance, it is anticipated that most laboratories which regularly check their work in serology by evaluation specimens will have excellent performance and others, though less reliable, will still have reasonably satisfactory performance. In expecting "excellence" in reliability in serologic tests of other laboratories, the Board of Health is asking only the quality of performance which has been and will continue to be provided by in its own central and regional laboratories.

Table 1.—Findings by Serologic Evaluations in Medical Laboratories in Florida

Quality of Performance	First Series		Second Series		Third Series	
	Number*	Per Cent	Number	Per Cent	Number	Per Cent
Excellent	46	30	42	34	73	67
Satisfactory	55	36	56	45	30	27
Poor to highly unreliable	51	34	27	21	6	6
Total	152	100	125	100	109	100

*Test results reported. Findings by different tests reported by one laboratory are tabulated separately.

Approval for the performance of premarital and prepartum serologic tests may be accepted as assurance that the laboratory has participated in the serologic evaluation and demonstrated satisfactory competence. Lists of such laboratories have been submitted to county judges and will be

revised annually on the basis of evaluations during the preceding year.

Methods which have proved so effective in improving the quality of performance in serologic work could, with advantage, be applied to other technical procedures.

Box 210

ABSTRACTS OF MEDICAL ARTICLES

THE VITAMIN K TOLERANCE TEST. By Paul N. Unger, M.D., Murray Weiner, M.D., and Shepard Shapiro, M.D. *Am. J. Clin. Path.* 18:835-851 (Nov.) 1948.

A continuation of previous studies demonstrating that the prothrombin time following large doses of vitamin K may be utilized as a liver function test of high sensitivity, this investigation was extended to include also some determinations of concurrent variations in the fibrinogen concentration of the plasma. On 123 persons, 132 vitamin K tolerance tests were made. The procedure is described and the results tabulated in detail, showing comparative results with other liver function tests and comparison of this and the other tests with findings in biopsy of the liver, at operation and at autopsy.

In summary, a standardized vitamin K tolerance test was used for estimating hepatic function with resulting excellent correlation with clinical and histologic findings. The vitamin K tolerance test was demonstrated to be a sensitive indicator of the functional state of the liver. Use of this procedure as a "scout" test for the detection of impairment of the liver is proposed.

UNTOWARD REACTIONS AND CUTANEOUS TESTING IN PENICILLIN THERAPY. By Joseph Farrington, M.D., Kathleen Riley, M.D., and Sidney Olansky, M.D. *South. M. J.* 41: 614-619 (July) 1948.

A practical clinical classification of the recognized types of dermatoses and other manifestations of hypersensitivity or toxicity which may be associated with penicillin therapy is presented. Some of the salient features of these reactions are discussed. Cutaneous testing is also discussed, and a table is presented which may be regarded as suggestive or corroborative but never conclusive in determining the causal role of penicillin in the altered reactivity encountered. The authors state that cutaneous testing should not be done haphazardly or indiscriminately; the time, site, concentration of the antigen and type of test employed should in each case be suited to the shock organ involved. Also, the value of cutaneous testing should not be overemphasized. In their experience, when properly done and interpreted, mucocutaneous testing proved helpful in about 24 per cent of the cases as a preadministration precaution or in the management of reactions of hypersensitivity.

AN EVALUATION OF 354 CONSECUTIVE HYSTERECTOMIES PERFORMED AT THE ORANGE MEMORIAL HOSPITAL. By Charles J. Collins, M.D. *Am. J. Obst. & Gynec.* 57:438-447 (March) 1949.

In view of considerable publicity given recently to the topic of unnecessary operations, Dr. Collins personally reviewed and analyzed the hospital case records of 354 consecutive hysterectomies, performed by seven members of the gynecologic and fourteen of the surgical staff of the Orange Memorial Hospital, Orlando. These 354 hysterectomies consisted of 120 total, 34 per cent, 163 subtotal, 46 per cent, and 71 vaginal types, 35 per cent. The greatest number of cases, 140, or 40 per cent, occurred in the age group 40 to 49 years. There were 167 hysterectomies, 46 per cent, performed in women under 40 years of age. The gynecologic service was responsible for 232, 65.5 per cent, of these cases and the surgical service 122, 34.5 per cent. There were two deaths in the series, a mortality incidence of 0.7 per cent in the abdominal hysterectomies and 0.56 per cent in the whole group. Both of these deaths were due to pulmonary emboli in the subtotal operations.

Ten patients, 2.8 per cent, had no preoperative symptoms. Abnormal bleeding was the chief complaint of 148 patients, 41.8 per cent, and 308, 87 per cent, complained of bleeding and/or pain and mass in the abdomen. Fibroids were discovered 205 times, 57.9 per cent, in the pelvic examinations prior to operation. In only 2 cases, 0.6 per cent, were normal pelvis reported. The preoperative findings appeared grossly to indicate operation in all but 5 cases, 1.4 per cent. Fibroids were found in 205 of the removed uteri, 57.9 per cent, by the pathologist. The uteri removed abdominally were reported normal (including cervicitis and pregnancy) 22 times, 7.7 per cent. Pregnancy or retained products were reported in 15 cases, 5.3 per cent. Of the 15 cases showing pregnancy or retained products on pathologic examination, 8 were recognized preoperatively and 7 were unrecognized. Hysterectomy is judged to have been indicated in 9 of these cases and not indicated in 6.

The clinical diagnosis was confirmed by the pathologist in 237 of the 283 abdominal hysterectomies, 83.7 per cent, and not confirmed in 46 cases, 16.3 per cent. In 235 cases confirmed by the pathologist, 83.3 per cent, the hysterectomy is considered justified, and in 16 of the unconfirmed cases, 5.7 per cent. Based on the 283 abdominal

hysterectomies, the removal of the uterus is considered justifiable in 251 cases, 89 per cent, and unjustifiable in 32, 11 per cent. In 3 of the total 354 cases, 0.8 per cent, the type of hysterectomy is judged misused.

From this study it is concluded that hysterectomy has been employed too liberally in the past, in the younger group of patients at the Orange Memorial Hospital, and that the incidence of 11 per cent unjustified operations is too high and should be reduced, but from the low rate of preoperative pelvic findings, 1.4 per cent, in which the operation was not grossly indicated and from the confirmatory pathologic support of the clinical diagnosis in 83.7 per cent of the cases, the abuse of the hysterectomy operation in this particular hospital is not conceded.



EOSINOPHILIC PLEURAL EFFUSION AND PERICARDITIS WITH EFFUSION IN AN ALLERGIC SUBJECT (REPORT OF A CASE TREATED WITH PYRIBENZAMINE). By Nelson Zivitz, M.D., and Julius A. Oshlag, M.D. *J. Allergy* 20:136-143 (March) 1949.

A hyperergic or allergic mechanism may produce a clinical picture, identical with that usually associated with degenerative processes, infections, or toxic agents in diseases of the heart, lungs and blood vessels. Accordingly, a case is reported which exemplifies the occurrence of arrhythmia, pneumonitis, and pericarditis and pleuritis with effusions in a patient whose asthma disappeared on onset, was absent during the sixty days of the illness and reappeared after recovery. Other significant features were 80 per cent eosinophils in the cell count of the pleural fluid, failure of reaction to the antibiotics, absence of proof of viral etiology, and recovery coincidental with the administration of large doses of pyribenzamine.

The authors stated that whether the recovery was spontaneous or resulted from the use of this antihistamine drug is not known. To their knowledge this is the first report of a case in which an attempt was made, with apparent success, to utilize the antihistamine drugs in therapy in such a case. These features, they concluded, with other clinical data discussed, even without pathologic findings or the reproduction of the clinical picture by a specific agent, seem sufficient to warrant adding this case to the accumulating literature illustrating a hyperergic etiology of cardiovascular disease.

CHRONIC SECRETORY OTITIS. By Walter T. Hotchkiss, M.D. South. M. J. 41:727-732 (Aug.) 1948.

Dr. Hotchkiss discusses a type of deafness caused by chronic secretory otitis or otitis serosa, and bases his observations on about 30 such cases in his practice in the past six years which, in spite of repeated myringotomy, have lasted from six months to three and a half years. He describes the symptoms, which are exactly the same as those of the acute form of the disease, and also the diagnostic procedure and the search for contributing causes. Allergy and nasal, tubal and pharyngeal disease were present in a goodly number of cases.

In conclusion, he emphasizes three points: In opaque drums diagnostic inflations are often necessary and are of great value. In a diagnostic inflation the usual signs of bubbles or moisture are often not heard, and the so-called choked inflation is of great diagnostic significance. There is the possibility that permanent perforation may be the method of choice in carefully selected cases.

CHRONIC INTESTINAL INTUSSUSCEPTION IN THE ADULT. By J. W. Snyder, M.D. South. M. J. 41:586-591 (July) 1948.

Dr. Snyder discusses intussusception as it occurs in the adult. In contrast to intussusceptions of infancy and childhood, which constitute real emergencies, intussusception in the adult is characterized by indefinite abdominal discomfort and illness extending over a considerable period of time. While it may be idiopathic in origin, as is usually the case in infancy, it is more often associated with some form of tumor, diverticulum or ulcer. Symptoms may be absent, especially if the tumor is small and the invagination nonobstructive, but they tend to be vague with signs of mild recurrent obstruction associated with symptoms of the prime causative factor. Abdominal colic appears, especially after meals, with slight nausea and with relief after the passing of gas or a stool. In diagnosis, final conclusions are often reached only after roentgen examination. Treatment is entirely surgical, and the type of operation should fit the condition encountered.

A case is reported which illustrates some of the problems and difficulties encountered in the diagnosis and treatment of this condition in the adult. It is observed that although this anomaly presents a highly interesting problem, its solution is beset with pitfalls, including many errors both of commission and omission.

THE INFLUENCE OF SUPRADIAPHRAGMATIC SPLANCHNICECTOMY ON THE HEART IN HYPERTENSION. By Emil M. Isberg, M.D., and Max M. Peet, M.D. Am. Heart J. 35:567-583 (April) 1948.

These authors present a study of the prolonged effects of splanchnicectomy on the heart in hypertension. Observations regarding the cardiac aspects in 384 patients with arterial hypertension, exclusive of malignant hypertension, treated surgically by the operation of bilateral supradiaphragmatic splanchnicectomy and lower dorsal sympathetic ganglionectomy, led to the conclusion that this therapy may have been beneficial in a significant percentage of hypertensive patients.

Five to twelve years after splanchnicectomy, 60 per cent of patients with hypertensive heart disease and 93 per cent of hypertensive patients with normal hearts were living. It was concluded that patients whose electrocardiograms show inverted T waves in both leads I and II, or both definite left axis deviation and abnormal T waves, have a 50 per cent chance for prolonged survival following this operation. Five years or more postoperatively, significant improvement was evident in the tracings of 41 per cent of the patients still alive whose preoperative electrocardiograms were abnormal. In practically all patients showing improvement in electrocardiogram or decrease in heart size, a significant reduction in blood pressure was maintained. One half the hypertensive patients in whom an enlarged heart was demonstrated did not survive five to twelve years.

Anginal seizures were frequently relieved following splanchnicectomy. Of patients with gallop rhythm prior to operation, 23.3 per cent survived five years or more. There is one chance in three of prolonged survival following operation for the hypertensive patient in congestive heart failure which requires digitalization preparatory to splanchnicectomy. Of 11 hypertensive patients who had had a coronary occlusion prior to splanchnic resection, 8 were living five to nine years postoperatively. This operation was, however, of no avail when pronounced cardiac enlargement with a variation greater than 50 per cent of predicted normal for frontal area or transverse diameter was present. Also, it was of little benefit to the patient with paroxysmal nocturnal dyspnea, for only 12.5 per cent survived five years or more.

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Make Reservations Early

Hollywood Beach Hotel

Seventy-Sixth

Annual Convention

Hollywood,

April 23-26, 1950

Eighteen scientific papers have been selected to be presented at the annual convention in Hollywood, April 23-26. Each essayist has been notified by Dr. Frederick K. Herpel, Chairman, Scientific Work Committee. Dr. Herpel and members of his committee, Drs. James R. Boulware, Jr., Jere W. Annis, Lakeland; James L. Borland, Jacksonville, spent Sunday, December 4 in Orlando examining the papers submitted for presentation. Stewart Thompson and Ernest Gibson were present also.

Arrangements for the annual meeting in Hollywood were continued on Sunday, December 11, as Dr. Stewart Thompson and Harold Parham spent the entire day at Hollywood conferring with hotel officials and Cabinet Chairman of Local Committees, Dr. Lloyd U. Lumpkin.

Dr. Walter C. Payne, President, on numerous occasions has spent an entire day at the Association's headquarters office since the beginning of his administration. His most recent visit was on Monday, December 5.

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Britain's Health Program Presented at University of Florida

Sir James Stirling Ross, former high ranking officer of the British Ministry of Health, appeared on the University of Florida lecture series at the auditorium of the Students' Union Building on the night of November 21, 1949. The public was invited to hear him.

A kindly, elderly man of small stature, Sir James has ruddy cheeks and an attractive Scotch accent. He began his talk by saying that his chief concern and interest were that the people of the United States be well informed concerning the National Health Service in Great Britain. He readily admitted that there were real difficulties involved in the service, but he stated that those difficulties were chiefly administrative. While this wrong or that wrong might exist, such wrongs, he contended, were isolated examples; otherwise, the House of Commons would be ringing with complaints. He called attention to the manner in which isolated facts can be used and abused in controversy and asked that the trivial be put aside in order to consider the over-all plan.

In his attempt to explain what the service is, he told why and by whom it was established, taking the audience back to 1907, and then gave a brief history of its progress through the years. He quoted Winston Churchill's statement in 1943 that all people should have equal opportunities to share in medical discoveries and advances, quoted the Oxford survey of 1945 which set forth the dreadful conditions due to mass evacuation of England's cities, and paid high tribute to leaders in the medical profession of Great Britain.

This distinguished Briton, credited with having personally played an important part in bringing Britain's health program into being, stated that in spite of all the difficulties the "practical working" of the plan is satisfactory. He averred that 95 per cent of England's Doctors of Medicine are cooperating, that the patient has freedom to choose his own physician and that the doctor-patient relationship is being preserved.

He admitted that there are four difficult problems involved: (1) overload of work on the family doctor; (2) delay in building health centers due to the economic blitz; (3) scarcity of nurses (an estimated 35,000 short); and (4) the problems of economy.

The high cost of the plan, he maintained, is due to the hospitals having been blasted during the war, to the increase in cost of care and operation in general, and to the unprecedented demand for dentistry and "spectacles." He asserted that there is no ceiling to the amount which can be spent—that it is necessary to see what a country can afford. He referred to the "new mandate" which has resulted from social and industrial sources and causes, and pointed to the revolutionary change in care for the "aged chronics." He affirmed confidently and declared positively that many of these chronics should never have been chronics at all.

Sir James closed his talk in fervent voice as he decried the term geriatrics and extolled the beauty of the word "eugenica." The chairman of the pro-

gram then made it clear to the audience that this was no debate, but questions were allowed

In reply to a question as to why the physicians of the United States are so opposed to this plan if the physicians of Great Britain are so well in accord with it, the speaker quoted Tennyson with somewhat doubtful effect and with no very apparent good point. Replying to a question which involved the efficiency and effectiveness of the plan, he dealt first in platitudes and then stated simply that an attempt is being made to improve the system and correct its shortcomings. While he was trying to answer a question which had to do with deficit spending, Sir James' voice seemed temporarily to take on a staccato-like quality, his thoughts seemed to become somewhat more remote, and his already ruddy complexion appeared to grow even ruddier.

There were several physicians in the audience, mostly from Gainesville, who wisely refrained from asking questions, lest they seem to enter debate. Most of them shared the impression that Sir James is a kind, conscientious, misinformed man. Many questions could have been asked, of course, which it would have been embarrassing to answer adequately: How can a sick person get an adequate medical study? How can the neurotics and malingerers be controlled? What is the attitude of the great middle class toward their new, so-called security? How can a government promise security to its commonwealth when that government is going broke?

A pertinent question which occurred to one or two was: Who is paying Sir James' expenses for this lecture tour? It seems unlikely that England, in its present financial plight, is spreading the gospel to America at its own expense. Is it our tax money that is footing the bill?

Here seems a fertile ground in which the medical profession may sow its thoughts and principles—the minds of our college students. Perhaps the American Medical Association will want to send lecturers to colleges throughout our country.

1950 Preview

No one was surprised to have President Truman declare late in November, after conferring of course with Federal Security Administrator Oscar Ewing, that his controversial Fair Deal health insurance program will be offered to the new session of the Congress convening this month and will be fought to a finish. Mr. Ewing is sat-

isfied that the health program is a political asset and is reported to have a special interest in its effect in New York, where he is said to hope to run for Governor this year.

Following the President's announcement, the Federal Security Administrator served notice not only that a stiff fight for the health insurance plan was contemplated but also that he was leaving for an on-the-spot study of Britain's health plan and Sweden's social security setup. While abroad, he planned to study the health programs of other nations as well so that everything possible can be gained from their experience with the problem. He is expected to return prepared to talk back when members of the Congress cite experiences detrimental to his pet scheme. The President is reported to have urged him to take plenty of time to familiarize himself with the situation, particularly in Britain. Doubtless Mr. Ewing will not extend his travels—at the taxpayers' expense, of course—to New Zealand, where the populace has just ousted the Labor government after fourteen years and has turned to the Conservatives for redress of its bureaucratic ills.

So the outpourings from the Federal Security Administrator and his cohorts will undoubtedly be more of the same with even greater emphasis. For many months now their glorification of a socialized medicine system here in the United States might well be mere transcribed recordings of what the British leaders told the British voters and persuaded them to buy in 1945. All the historically tragic experience with socialized medicine has been brushed off by them, as by the British leaders, as mere poppycock. Those who even casually studied what they were proposing in Britain warned that it could not work. And it has not.

Yet off goes Mr. Ewing to study a system deeply in the red and one that would have folded up long ago except for the American taxpayers' dollars. Despite the wholesale demonstration of failure, our government adheres tenaciously to the same pattern and would force it upon us. Britain's plight today could be a preview of happenings on this side of the Atlantic if the Administration has its way.

When United States Senator Walter F. George of Georgia, a staunch opponent of socialized medicine, visited Florida recently, he said the best way to prevent America from becoming a welfare state is to have a stronger government in Washington. "A much stronger government would put us on

the right course in a short length of time," he remarked. His prescription for a stronger government is the election of strong men to office, with the average citizen giving more thought to voting and to the choice of candidates for political office.

This would seem to be particularly good advice to physicians, who have come face to face with a grave political problem whether they would or not and who must face up to their political responsibility. Administration supporters do not minimize the influence of doctors with legislatures and the Congress. They bank heavily, however, on doctors having less influence with the 60,000,000 American families having incomes of \$5,000 a year or less who cannot afford a serious illness but can vote.



The 1949 Epidemic of Investigations F. M. A. Headquarters Visited

Action of the Antitrust Division of the United States Department of Justice in suddenly "investigating" the American Medical Association, state and county medical societies affiliated with it, and other medical organizations made strange medical history during the year now ended. More than a score of these medical groups scattered throughout the nation were the victims of this epidemic of investigations.

The activities of the Federal Bureau of Investigation in searching the files of medical societies and medical service plans elicited a prompt and forthright statement from the Board of Trustees of the American Medical Association "protesting the use of a police arm of the Government" in this way. This public statement is published in full in the Journal of the American Medical Association for October 15, 1949. With this pronouncement every member of the medical profession will wish to be thoroughly familiar.

The office of the Florida Medical Association in Jacksonville was visited by the local representative of the F. B. I. on September 26, 1949, and the information sought was duly given by the proper officials. This inquiry and the numerous other "investigations" now form a significant part of the record for 1949. What do they portend for 1950 and for the future of medicine? It is perhaps too early to comment, but every member of the Association is free to draw his own conclusions.

Rural Health Conference February 3 and 4

The Committee on Rural Health of the American Medical Association announces the next annual conference on Rural Health for February 3 and 4, 1950, in Kansas City. A conference of state chairmen will precede the meeting, opening on the afternoon of February 2 and continuing through a dinner meeting.

Five discussion subjects dealing with the problem of action at the local level have been selected for the panel sessions. These panel study subjects are: (1) rural medical facilities at the local level; (2) relation of agricultural extension service to rural health problems; (3) community responsibility for health service in rural areas; (4) methods of prepayment for health services in rural areas; and (5) the responsibility of the medical schools in the rural health program.



American Academy of General Practice 1950 Scientific Assembly

On February 20, 21, 22 and 23 the American Academy of General Practice will hold its second Scientific Assembly in St. Louis. The Kiel Auditorium will be headquarters for the meeting, and the scientific sessions will be held in the Opera House of the Auditorium. The excellent facilities available will make possible a greater number of exhibits, both technical and scientific, than last year and of the same high quality.

The American Academy of General Practice is the only national scientific organization in the country formed by and for general practitioners of medicine and surgery. Founded only two years ago, it now has a membership of well over 10,000 and has constituent chapters in most states. The first Scientific Assembly, held in Cincinnati in March of last year, was an overwhelming success, with a final registration of 3,529. A great precedent was established, and the 1950 Scientific Assembly is expected to be an even more outstanding success.

General practitioners who are members of the American Medical Association are invited to register. Further information may be obtained from Mr. Mac F. Cahal, Executive Secretary, American Academy of General Practice, 406 W. Thirty-Fourth St., Kansas City 2, Mo.

A. M. A. Washington Representative Visits Florida

Dr. Frank E. Wilson, Deputy Director of the Washington, D. C., Office of the American Medical Association, recently visited representative groups of medical societies in Florida to establish liaison between the American Medical Association and the state medical societies. He found that the physicians of Florida are well aware of legislation on health matters. Beginning his tour of the state in Pensacola, he spent November 23 there, was in Tampa the next two days, visited Miami from the twenty-fifth through the thirtieth and stopped in Jacksonville on December 1.

YOUR BLUE SHIELD

New Blue Shield—Blue Cross Contracts

New contracts providing increased benefits under the Florida Blue Shield and Blue Cross Plans are now being offered to all present members of the plans, as well as to new groups at the time of enrolment, for issuance on and after Jan. 1, 1950. These new contracts will be called the Blue Shield—Blue Cross "Series 7" Contracts.

Benefits Under New Blue Shield Contract

For the first time since the organization of the Blue Shield Plan, in-hospital medical care will be provided. Commencing on the fourth day of a hospital stay for nonsurgical cases, an allowance of up to \$5 a day will be paid to a participating physician in charge of the case for each day a visit is made. These payments will extend for twenty-eight days in each contract year. Thus, the maximum in-hospital medical benefits payable in any one contract year will be \$140 per person for each member included in the subscriber's contract.

The present Blue Shield Schedule of Benefits, which was revised a year ago with many changes upward in benefit payments, will remain in force.

Waiting periods under the new Blue Shield contract are: nine months for maternity care (previously ten months), and no waiting period for tonsillectomies and adenoidectomies (previously three months).

In addition to medical, surgical and obstetric care, Blue Shield members, when hospital in-pa-

tients, are entitled to the following additional benefits rendered by a participating physician not in charge of the case: anesthesia services, up to \$10 each hospital admission; pathologic services when in connection with surgery, up to \$7.50 each hospital admission; and x-ray service (not including therapy) when in connection with surgery, up to \$15 each hospital admission.

Blue Shield benefits covered outside of the hospital are: minor surgery, and x-ray services for suspected acute fractures and dislocations.

It should be noted that the present Blue Shield contract will not be entirely replaced by the new contract. Present members are being given the opportunity to convert their coverage immediately if they so desire, or on the anniversary dates of the groups through which they are enrolled. New members will be issued the new contract at the time they are enrolled. Undoubtedly some of your patients will be holders of the present Blue Shield contract.

In order to make it as easy as possible for you and your secretary to determine the benefits to which your Blue Shield patients are entitled, holders of the new contract will present to you identification cards entirely different in appearance and size from the identification cards for present benefits. These new cards, when unfolded, are three times larger than the cards now in use, and contain much helpful information for the contract holder. Subscribers who have not converted their coverage will continue to receive benefits under the present Blue Shield contract.

Benefits Under New Blue Cross Contract

The new Blue Cross contract provides the following benefits: room allowance now up to \$7 a day; antibiotics, up to \$10 each hospital admission; electrocardiograms, up to \$10 each hospital admission; basal metabolism tests, up to \$10 each hospital admission; electroencephalograms, up to \$10 each hospital admission; diathermy and physiotherapy, up to \$10 each hospital admission; oxygen therapy allowance now unlimited (previously covered up to \$25); full payment for use of operating room, laboratory examinations (except pathology, which is covered under Blue Shield), drugs and medicines, solutions and dressings; x-ray (not including therapy), up to \$15 each hospital admission; administration of anesthesia by hospital employee, up to \$10 each hospital admission; anesthesia supplies to outside M.D. anesthetist, no limit; transfusion setup, up to \$10 each hospital admission; maternity care (under family contract), benefits as outlined up to \$75; and emergency room service (within twenty-four hours of accident), up to \$5.

The waiting period for maternity care has been reduced from ten to nine months. Hospital care for tuberculous and mental conditions is now covered for thirty-one days during the life of the contract (previously covered for seven days each contract year).

ANNUAL CONVENTION

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April 23-26, 1950

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BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Morton M. Halpern of Miami announce the birth of a son, Jon J., on Oct. 17, 1949.

Dr. and Mrs. Lawrence G. Hebel of Palatka announce the birth of a daughter, Gail Suzette, on Nov. 6, 1949.

Dr. and Mrs. Paul F. Hutchins of Jacksonville announce the birth of a son, Paul Francis, Jr., on Nov. 5, 1949.

Dr. and Mrs. Jackson L. Allgood, Jr., of Jacksonville announce the birth of a son on Nov. 22, 1949.

Dr. and Mrs. Harry Needelman of Miami Beach announce the birth of a daughter, Felicia Linda, on Nov. 4, 1949.

Dr. and Mrs. Ralph Robbins of Miami Beach announce the birth of a son, Christopher, on Oct. 13, 1949.

Marriages

Dr. John A. Toomey of Cleveland, Ohio, and Miss Helen Toomey of Hollywood Beach were married on Oct. 28, 1949.

Dr. Hyman Merlin of Miami and Miss Ester Argintar of Miami were married on Sept. 18, 1949.

Dr. Maurice I. Edelman of Miami and Miss Josephine L. Weiss of Asheville, N. C. were married on Oct. 29, 1949.

Dr. Julio J. DePoo and Mrs. Olga Splinter Renedo, both of Miami, were married on Oct. 9, 1949.

Deaths—Members

Dr. Julius A. Oshlag, Miami Beach Nov. 9, 1949
Dr. Robert E. Repass, Miami Nov. 27, 1949

STATE NEWS ITEMS

At the Southern Medical Association's 1949 annual meeting, which was held in Cincinnati, Ohio, November 14-17, forty-five members of the Florida Medical Association registered. They were Drs. Alan Brown and William G. Mason, Clearwater; Allen E. Kuester, Cocoa; Charles R. Burbacher, Coral Gables; James R. Nieder, Delray Beach; William D. Wells, Ft. Lauderdale; H. Quillian Jones, Ft. Myers; George A. Dame, Fernandina; William C. Thomas, Gainesville; Redden L. Miller, Graceville; Joseph M. Burton, Homestead; George P. Beach, Sullivan G. Bedell, James L. Borland, Clarence D. Rollins and Wilson T. Sowder, Jacksonville; Jere W. Annis and Marion W. Hester, Lakeland; James L. Anderson, M. Jay Flipse, Thomas S. Gowin, William M. Howdon, Leslie M. Jenkins, Walter C. Jones, Donald F. Marion, John D. Milton, E. Sterling Nichol, Benjamin G. Oren, J. Randolph Perdue, Gerard Raap, Donald W. Smith, Joseph S. Stewart, Richard F. Stover and Herbert W. Virgin, Jr., Miami; Chas. J. Collins and Robert L. Tolle, Orlando; Arthur J. Butt, Jr., Mayhew W. Dodson and Wilton E. Tugwell, Pensacola; Charles E. Aucremann, St. Petersburg; Chadbourne A. Andrews, Jas. L. Estes, Chas. McC. Gray, Frank T. Linz and Douglas D. Martin, Tampa.

The fifth annual meeting of the Southeastern Allergy Association has been scheduled for the Columbia Hotel, Columbia, S. C. on Saturday and Sunday, Feb. 11-12, 1950. Guest speakers will be Jonathan Forman, president of the American College of Allergists and Dr. Theodore Squire, president-elect of the American Academy of Allergy. Panel discussions will include one on "Pediatric Allergy" and one on "Office Procedure."

Dr. Frank G. Slaughter of Jacksonville was the guest speaker at an open meeting sponsored by the Woman's Auxiliary to the Pinellas County Medical Society in St. Petersburg on November 15. Dr. Slaughter's subject dealt with the importance of doctors in community and civic life.

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Dr. Gordon H. Ira of Jacksonville was the guest speaker at the November meeting of the Woman's Auxiliary to the Duval County Medical Society. Dr. Ira spoke on the education program for the Auxiliary.

Dr. Arthur J. Butt, Jr., of Pensacola addressed the recent meeting of the Southern Medical Association in Cincinnati, Ohio, on the subject of prevention and treatment of kidney complications resulting from sulfa drugs.

Dr. Edward Canipelli of Jacksonville addressed the Knights of Columbus on public health at a November meeting held in Jacksonville.

Dr. John H. Tanous of Miami Beach recently addressed the pre-medical students at the University of Miami.

Dr. Hugh A. Carithers of Jacksonville attended the quarterly meeting of the Florida Children's Commission in West Palm Beach in November.

Dr. Bruce Cominole of Daytona Beach was the featured speaker at the local Lion's Club recently. He discussed the probable harm done by fear of cancer.

Dr. Ashbel C. Williams of Jacksonville has been elected state president of the American Cancer Society, and chairman of the executive committee for the state of Florida.

The New Orleans Graduate Medical Assembly is sponsoring a post-clinical tour to San Juan, Puerto Rico to follow the 1950 annual meeting scheduled for New Orleans, March 6-9. The party will travel by airplane and the planned itinerary also includes the Virgin Islands; Ciudad Trujillo, Dominican Republic; Kingston and Montego Bay, Jamaica and Havana.

Medical programs and visits to hospitals have been arranged. Departure will be from New Orleans Saturday, March 11 to return on Sunday, March 26. For further information, write to the office of the Assembly, Room 105, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Drs. E. Frank McCall, Samuel R. Norris, Irving J. Strumpf and Max Suter, all of Jacksonville, have been invited to lecture at the Obstetric Seminar in Augusta, Georgia, December 12-16.

Drs. F. Hardy Bowen, Samuel M. Day, Jr., and Leonard M. Moe, all of Jacksonville, attended the convention of the Seaboard Airline Railroad Surgeons held in Havana, Cuba in November. Dr. Day presented a paper to the group on "The Management of Severe Burns."

Dr. George A. Dame of Fernandina has been certified as a diplomate in the Founders Group by the American Board of Preventive Medicine and Public Health.

Dr. Nathan Weil of Jacksonville was the guest speaker at the November meeting of the Stephens College Alumni Club in Jacksonville.

Dr. Joseph L. Selden, Jr., of Ft. Myers was honored as the guest speaker at the November Parent Teacher's Association meeting in that city. Dr. Selden spoke on the topic, "Health of Parents."

Dr. Benjamin J. Bond of Winter Haven was the principle speaker at the monthly supper meeting of The First Presbyterian Young Adults on Sunday, November 20. Dr. Bond's subject was "The Crisis of Birth."

Dr. Arthur J. Henry, Jr., of Tallahassee, addressed the local Business and Professional Women's Club at a recent meeting on the subject, "Health as a Necessity for Success."

Dr. Richard C. Cumming of Ocala was the guest speaker at the regular meeting of the Dunnellon Woman's Club, at which time he discussed community health and sanitation.

Dr. Paul G. Shell of Ft. Lauderdale recently addressed the Dania Rotary Club on the subject of cancer. Dr. Shell explained methods of treating cancer and the research that is being carried on to determine the cause of the disease.

Dr. Samuel G. Hibbs of Tampa recently participated in a program on mental health problems presented to a local group of parents, teachers and other interested adults at the Woodrow Wilson Junior High School in that city.

Dr. Roger Phillips of Orlando was the guest speaker at the regular monthly meeting of the Children's Church Study Group held at the College Park Methodist Church in that city.

Dr. John F. Lovejoy of Jacksonville has been named the new president of the local Kiwanis Club. Dr. Lovejoy previously served as secretary of this club.

COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Charlotte-Glades

The November meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society was held at Aqua Vitae Springs. Dr. Wesley W. Wilson of Tampa was the guest speaker. He presented a paper on "Angiomatous Lesions of the Skin." Members present included Drs. Harold S. Agnew, Henry P. Bevis, Godfrey L. Beaumont, Isaac W. Chandler, Hubert W. Coleman, Miles A. Collier, Merle C. Kayton, Carl J. Larsen, Gordon H. McSwain, Ruth M. Miller, Wesley S. Pyatt, Zaven M. Seron and Edwin C. Northup.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society has elected the officers who will serve in 1950. They are as follows: Dr. J. Lloyd Massey, President, Quincy; Dr. John T. Benbow, Vice President, Chattahoochee. Dr. Edward C. Love, Jr., Quincy, was re-elected Secretary-Treasurer. Dr. George H. Garmany and Dr. Bricey M. Rhodes, both of Tallahassee are the delegates to the Seventy-Sixth annual convention of the Florida Medical Association, with Drs. J. Lloyd Massey of Quincy and Dr. Merritt R. Clements of Tallahassee as alternates.

Marion

The Marion County Medical Society held its regular meeting at the Magnolia Lodge at Crystal River. Future meetings of the society have been scheduled at 7:30 p.m. on the third Wednesday for dinner meetings with the Woman's Auxiliary, which is presently being organized.

The following members were present: Drs. William H. Anderson, Jr., Hugh H. Barfield, K. R. Cammack, T. Hartley Davis, Bertrand F. Drake, William H. Garvin, Jr., Eaton G. Lindner, John D. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, John P. Moore, Robbins Nettles,

Eugene G. Peek, Eugene G. Peek, Jr., Ralph E. Russell, E. Laurence Scott, Robert E. Thompson, Herbert M. Webb, Jr. and Jack M. Waldrep. Guests included Dr. William B. Moon, Crystal River, Dr. James Robert McCord of Ocala, formerly professor of obstetrics at Emory University School of Medicine, and Dr. Luther Alexander Brendle, new director of the Marion County Health Unit, and former director of the Knoxville, Tennessee Health Unit.

OBITUARIES

Louis Richard Marshall

Dr. Louis R. Marshall was found dead in his hotel room in Jacksonville on Oct. 25, 1949. He was 49 years of age.

Dr. Marshall was born in Cleveland, Ohio on Dec. 11, 1899. He received his premedical training at the Ohio State and Western Reserve universities. In 1926 he was graduated from Jefferson Medical College of Philadelphia and three years later obtained his license to practice medicine in Florida. His internship was taken in the Cleveland City Hospital, and later he served residencies in the Jackson Memorial Hospital, Miami, and the Episcopal Eye, Ear and Throat Hospital, Washington, D. C. In November, 1934 Dr. Marshall joined the Veterans Administration as a specialist in ophthalmology and otolaryngology. A veteran of over two years' service in World War II, he was released to inactive duty June 16, 1946 with the rank of lieutenant colonel.

Dr. Marshall was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association.

William Henry Watters

Dr. William H. Watters of Coconut Grove died at his summer home in Hyannis, Mass. on Oct. 11, 1949 at the age of 73 years.

Dr. Watters was born in Searsport, Maine in 1876. After graduation from McGill University in Montreal, he attended the Boston University School of Medicine, receiving his medical degree in 1900. For twenty years he taught bacteriology

(Continued on page 443)



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Alexander Brunschwig	Memorial Hospital	Operability of cancer
Meredith F. Campbell	New York	Urology
Louis K. Diamond	Harvard Medical School	Rh factor
Arthur C. DeGraff	New York	Heart
Maxwell Finland	Harvard Medical School	New antibiotics
Richard H. Freyberg	Cornell University	Compound E in arthritis
Chevalier L. Jackson	Philadelphia	Bronchoscopy
Herbert C. Maier	Presbyterian Hospital	Chest surgery
James F. Norton	Margaret Hague Maternity Hospital	Extra peritoneal caesarean section
Eugene P. Pendergrass	Pennsylvania Hospital	X-ray
E. R. Pund	University of Georgia	Smear diagnosis of cancer
R. L. Sanders	Memphis	Biliary and peptic ulcer surgery
Albert M. Snell	Mayo Clinic	Medical treatment of gallbladder and liver
Donald H. Stubbs	George Washington University	Vascular and circulatory collapse
Walter G. Stuck	Nix Hospital	Backache
Oscar Swineford	University of Virginia	Allergy
Willard O. Thompson	Chicago	Misuse of estrogens — obesity
Richard W. TeLinde	Johns Hopkins Hospital	Cancer in situ (cervix)
Julius L. Wilson	Tulane University	Chest disease
Harold G. Wolff	Cornell University	Headache

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and pathology at his alma mater. A specialist in internal medicine, he had practiced in Coconut Grove for the past twenty-three years. At the time of his death, he was Professor Emeritus of Preventive Medicine in the Boston University School of Medicine, and in recent years he had been a board member and associated with the Department of Legal Medicine of the Harvard University Medical School.

For many years Dr. Watters was a member of the staff of St. Francis Hospital in Miami Beach and recently of the staff of Doctors Hospital. He was a member of the Florida Medical Association for twenty-four years; he was also a member of the Dade County Medical Association and a fellow of the American Medical Association. He held membership in the Royal Arch Masons at Lynn, Mass., was a member of the Plymouth Congregational Church and was affiliated with a number of civic and social organizations in the Miami area.

Surviving are his widow, Mrs. Gertrude Watters, and a son, Dr. Preston H. Watters, with whom he was associated in practice in Coconut Grove; and a daughter, Mrs. Willard Hollander of Swarthmore, Pa.

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 20. Vaginal Approach to Pelvic Surgery, One Week, starting March 6.

OBSTETRICS—Intensive Course, Two Weeks, starting March 6.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Hematology, One Week, starting May 8. Gastro-Enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting March 6.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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Highlights of the National Fall Conference

Auxiliary Members:

It was indeed a genuine pleasure and a rare privilege you afforded when you sent me to Chicago to the National Fall Conference of the Woman's Auxiliary to the American Medical Association. It was more than inspiring to meet with the presidents and presidents-elect from practically every state in our nation, together with every national committee chairman and a majority of the national officers. The interest in Auxiliary work can well be measured by the enthusiasm of this well attended conference. There was not one dull moment throughout the whole two days, and the cordial greetings I received from the many friends I made at the convention in Atlantic City filled my heart to overflowing. I soon learned

(Continued on page 446)

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that their troubles, problems and adversities were similar to ours; so the task was ours to glean from this conference the suggestions that would help meet the needs of the present day.

Mrs. David B. Allman, our national president, in her gracious manner opened the meeting with a warm welcome. But it was Mrs. Arthur A. Herold, our president-elect, to whom we must toss the orchids. Being petite, charming and truly "deep South," she presided over the two day conference with ease, dignity and ability. She endeared herself to one and all of us, and exemplified her ability as a leader.

Throughout all of the reports and discussions of our national chairmen, certain points were emphasized by each speaker, but, in summary, they meant the same though expressed differently, namely, Education, Public Relations, Legislation and Membership.

By being better informed, we can in a more capable and efficient manner perform our duties and meet our responsibilities. We must not slacken our efforts in Public Relations; rather must we work in a more determined manner than ever. Let us always be on the alert for matters pertaining to Legislation that must be stopped or encouraged.

By Membership is meant that every doctor's wife should become a member of the Auxiliary and join in the crusade with her husband for the preservation of our "American Way of Life" and the fight to save our country from becoming a socialistic state. Strength in numbers comes from increased membership, either by organizing new auxiliaries, strengthening the membership in existing auxiliaries, or enrolling members at large.

Throughout every report and lecture there was an imperative urge to do and an interweaving of the principles of the aforementioned phases of Auxiliary work, which I shall repeat for emphasis: Education, Public Relations, Legislation and Membership. Let us concentrate with all of our forces on these phases of Auxiliary work, and then our responsibilities will become privileges and a source of pleasure.

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BOOKS RECEIVED

CLINICAL INTERPRETATION OF LABORATORY TESTS. By Raymond H. Goodale, M.D. Price, \$6.50. Pp. 605. Philadelphia: F. A. Davis Company, 1949.

The numerous advances in all branches of clinical pathology make it important today to have at hand an interpretative text. This working manual for the general practitioner, intern, technologist, nurse and student interprets the significance of the individual test and lists the diagnostic tests for each disease. Designed to bring together the laboratory and the clinic, the book is divided into two parts, the first entitled "Body Fluids, Excreta, and Functional Tests" and the second "Diseases with Associated Laboratory Findings."

Each disease which lends itself to laboratory diagnosis is briefly outlined and followed by a list of changes to be expected in the examinations which are given in order of importance. Diseases with associated laboratory findings are discussed according to the various systems. Among the topics fully discussed are the physiology, normal values and significance of abnormal values of the various body fluids and excreta; basal metabolic rates; liver function tests; bacteriologic, viral and mycotic examinations; skin tests; poisons; chemotherapy and antibiotic therapy in relation to bacteriology; and proper methods of preparing body fluids, excreta, and tissues for the laboratory.

CLINICAL AUDIOLOGY. By Maurice Saltzman, M.D. Price, \$5.00. Pp. 195. New York: Grune & Stratton, 1949.

The audiologist as a medical specialist fills a prevailing gap in the realm of specialized service by utilizing the sciences of physics, psychophysiology and psychology in the elucidation of otologic entities. The author of this book, Dr. Maurice Saltzman, Assistant Professor of Otorhinology, Temple University School of Medicine, and a clinical otologist for twenty-five years, has excelled as a diagnostician and is a profound student of neurophysiology, psychology and physics. He is a master of his subject, and the book is written in simple and pleasant style—so states Dr. George M. Coates, Chief Editor, Archives of Otolaryngology and Professor of Otolaryngology Emeritus, University of Pennsylvania, in the introduction.

The purpose of the book is the interpretation of otologic observations in the light of the sciences of psychophysics and psychophysiology. Audiograms present characteristic features in many forms of hearing impairment. By means of graphs authentic audiometric patterns for the various types of deafness discussed in the text are established. Dr. Matthew S. Ersner, Professor and Head of the Department of Otorhinology and Rhinoplasty, Temple University School of Medicine, states in the foreword that he regards the book with its wealth of new ideas as worthy of being deemed the "pioneer textbook" of a new medical specialty, which covers so completely and concisely the fields of hearing and deafness that it should become the standard text on these subjects. He concludes: "A student of psychology will find authoritative information in it. To the physician and medical student, this book presents the proper clinical approach to the study and treatment of deafness and tinnitus. The interrelationship between audiologic phenomena and the clinical practice of internal medicine, neurology and pediatrics is particularly well brought out by the author."

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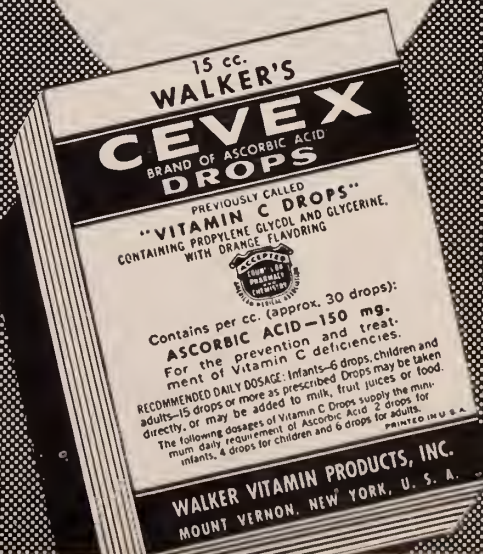
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scope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp.
Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol.
35, 6-1-25, No. 11, 590-592.

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Dermatology

Dr. Moses Paulson, Baltimore

Gastro-enterology

Dr. Emil Novak, Baltimore

Gynecology

Dr. John Parks, Washington, D. C.

Gynecology

Dr. William Barry Wood, St. Louis

Medicine

Additional speaker to be announced

Medicine

Dr. H. Houston Merritt, New York

Neuropsychiatry

Dr. William J. Dieckmann, Chicago

Obstetrics

Dr. Parker Heath, Boston

Ophthalmology

Dr. Walter G. Stuck, San Antonio

Orthopedic Surgery

Dr. Theodore E. Walsh, St. Louis

Otolaryngology

Dr. William Boyd, Toronto, Canada

Pathology

Dr. William J. Orr, Buffalo

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Every available means for checking has been used. Notification of errors or omissions should be mailed to P. O. Box 1018 (Fla. Theatre Bldg.) Jacksonville 1, for use in compiling the next Journal.

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochran, Daytona Beach	
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	
Florida Specialty Societies			
Allergy Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Heart Association	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewitt, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	June 3, '50
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, June 25-27, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. O. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, March 30-31, '50
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
S. E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	St. Petersburg, April 5-7, '50
Southeastern Allergy Assn.	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., Feb. 11-12, '50
Southeastern, Am. Urological Assn.	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1950
Southeastern Surgical Congress	R. J. Wilkinson	B. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
Gulf Coast Clinical Society	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	

Component Societies by Medical Districts

The page under the above caption which appears regularly in this section of The Journal has been omitted for the January issue. The County societies elect their new officers at the end of the year and as this Journal goes to press, the names of the presidents and secretaries for 1950 have not been received. Consult the December Journal for the names and addresses of last year's county society officers.



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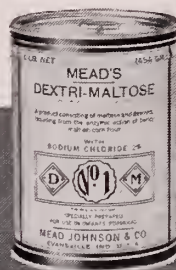
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

FEBRUARY, 1950

No. 8

IN THIS ISSUE

Pyuria

Frank J. Pyle



Urinary Incontinence

Arthur J. Butt

W. E. Kittredge



Malignant Neoplasia

Lucien Y. Dyrenforth

Alpheus T. Kennedy



The Rice Diet

An Editorial



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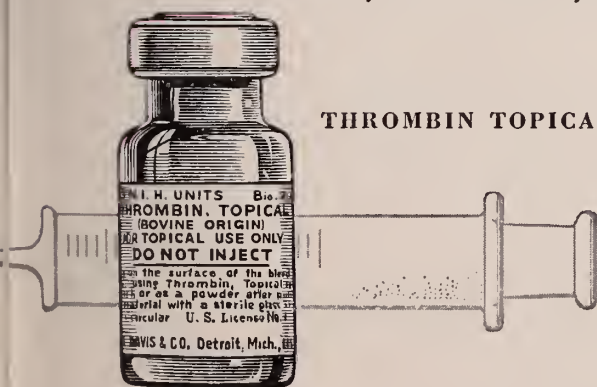
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CONTENTS

SCIENTIFIC ARTICLES

Pyuria: A Study of One Hundred Cases, Frank J. Pyle, M.D.	475
Urologic Consideration of Urinary Incontinence in the Female: Analysis of One Hundred and Twelve Cases, Arthur J. Butt, Jr., M.D., and W. E. Kittredge, M.D.	479
Multiple Malignant Neoplasia: Case Report of an Unusual Combination of Unre- lated Cancers, Lucien Y. Dyrenforth, M.D., and Alpheus T. Kennedy, M.D.	484
Complications of Anorectal Surgery, Tom E. Smith, M.D.	488

ABSTRACTS OF MEDICAL ARTICLES

Drs. Frank C. Metzger, Donald G. Stannus, Max Suter, John P. Michaels, Joseph Farrington, J. Brown Farrior, H. Milton Rogers, Abraham R. Hollender, J. William Douglas, Wendell J. Newcomb, Frederick H. Bowen, I. Leo Fishbein, Louis M. Orr, II, Emil M. Isberg, Albert V. Hardy, Charles K. Donegan, William H. Kelley, Claude G. Mentzer, Carlos P. Lamar and Camillus S. L'Engle	492
---	-----

EDITORIALS

The Rice Diet	502
In One Door and Out the Other	502
Those Selfish Doctors	503

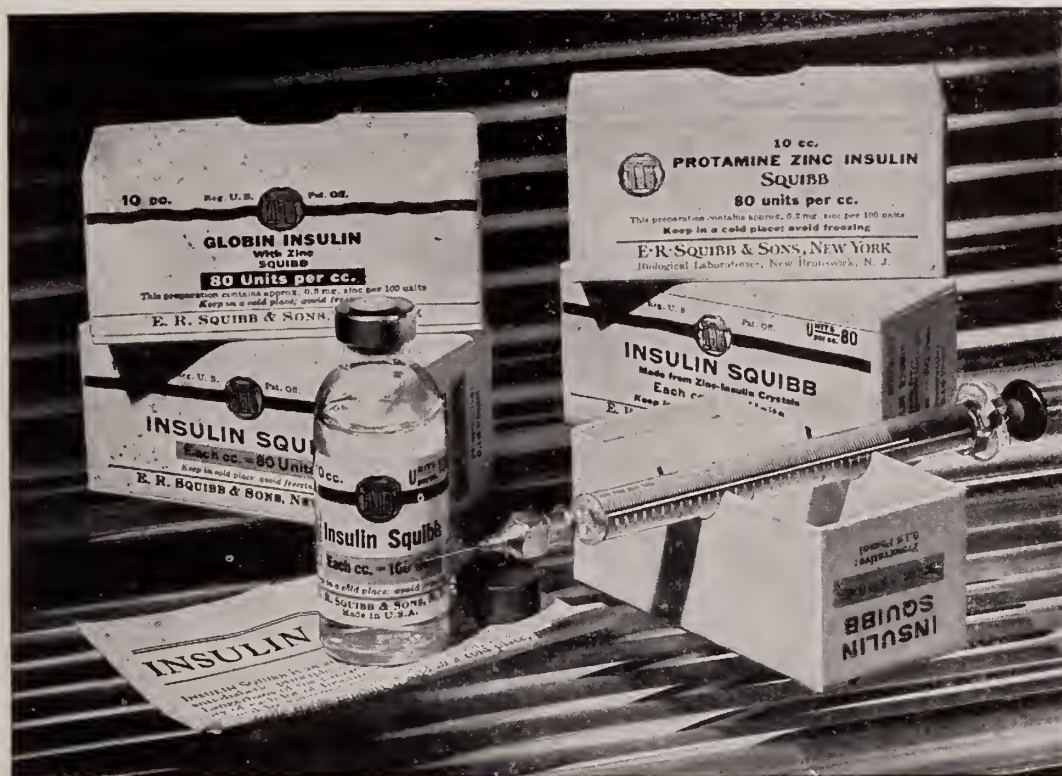
COMMENTARIES

Postgraduate Assembly in Endocrinology.....	503
Seminar on Cancer	504
Graduate Medical Education Schedule.....	504
Report of Delegates to A. M. A. Convention	505

GENERAL FEATURES

Officers and Committees	500
Your Blue Shield	509
Births and Deaths	509
State News Items	509
New Members	511
Component Society Notes	511
Obituaries	514
Woman's Auxiliary	517
Books Received	519
Schedule of Meetings	525
List of County Medical Societies, Presidents and Secretaries	526

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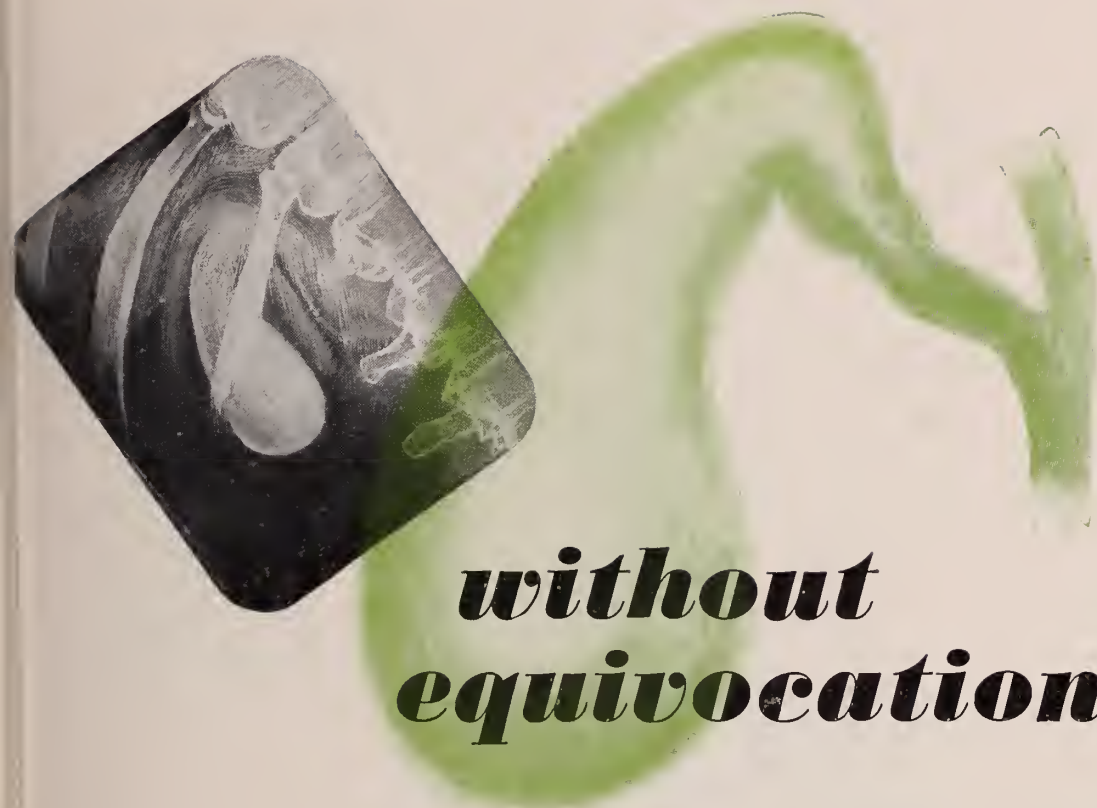
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1. Brewer, A. A.: Radiology 48:269, 1947.

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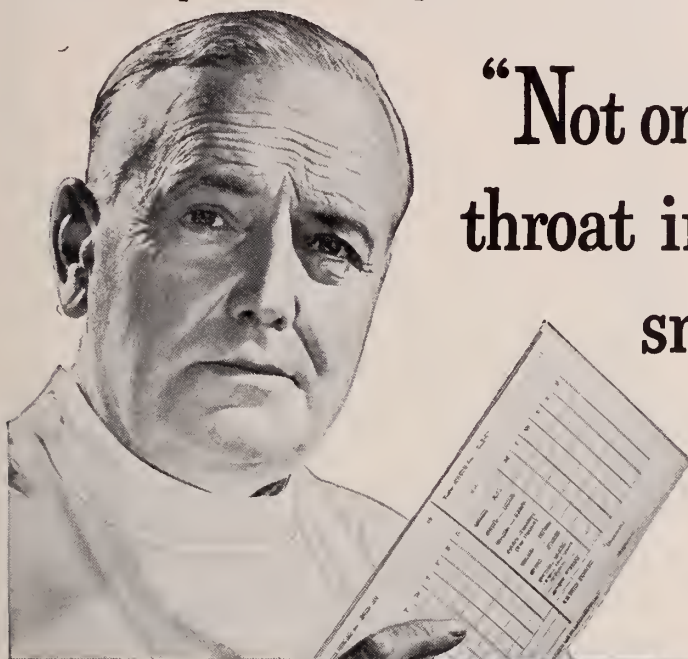
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Pyuria: a Study of One Hundred Cases

FRANK J. PYLE, M.D.

ORLANDO

Pyuria, pus or white blood cells in the urine, is a common and important finding. The cells may appear in macroscopic or microscopic quantity. A diagnosis of pyuria should be made from the second portion of the urine in the two glass test in the male, and from a catheterized specimen in the female, for voided urine in the female may contain pus cells from the vagina or urethral glands. Also, pyuria cannot be determined by gross examination of the specimen even if the urates are dissolved by heating and the phosphate eliminated by acetic acid. The diagnosis can be made only by microscope. The addition of a small amount of 1 per cent acetic acid crenates the red blood cells and clears the pus cell cytoplasm, thus making the nucleus stand out distinctly. Further study of the urine includes culture and stained smear.

Pyuria having been established as present, its cause must be determined. The causes are listed in figures 1, 2 and 3, and must be carefully searched for.

Simple roentgen examination defines 95 per cent of calculi; the remaining 5 per cent being non-opaque, it reveals the position of the kidneys and rules out extrarenal pathology in many cases. A satisfactory urologic examination then includes

careful investigation for urethritis, specific and nonspecific, and for stricture. The two glass test in the male and inspection of Skene's glands in the female are required. It is usually wise to pass a 24 sound or bougie to rule out stricture and assure that a cystoscope will pass readily. Digital examination by rectum should be routine in all men over 50. This routine will render the examiner familiar with the normal and thus facilitate his recognition of the abnormal. In conjunction with the roentgen studies, such examination can rule out calculi in the prostate. All are familiar with the common adenoma or so-called benign hypertrophy of the prostate, but too many early carcinomas escape detection. Routine smears from the prostate and seminal vesicles should be examined for pus cells. It is my belief that prostatitis is frequent in all age groups and not often caused by previous gonorrhea.

Cystoscopic examination must be careful and thorough. Inspection of the bladder and prostatic

Cystitis — primary
Tuberculosis
Calculus
Diverticula
Ulcer
Tumors
Bilharzia

Fig. 2. Causes of pyuria—vesical

Prostatic	{ Prostatitis Prostatic abscess Calculus
Seminal Vesicular	{ Adenoma of prostate (benign prostatic hypertrophy) Cancer of the prostate Seminal vesiculitis
Urethral	{ Urethritis: Gonorrhea Nonspecific Stricture

Fig. 1. Causes of pyuria—lower urinary tract

Renal	{ Pyelonephritis (including pyelitis) Renal abscess (including carbuncle) Pyonephrosis (including infected hydronephrosis) Tuberculosis Stricture (ureteropelvic) Calculus
Ureteral	{ Stricture Kink: Nephroptosis Ectopic kidney Calculus Obstruction (extraureteral)

Fig. 3. Causes of pyuria—upper urinary tract

urethra will determine whether or not vesical calculi, tumors or ulcers are causing pyuria. It will furthermore reveal the size and shape of the prostate, and median bars when present. Study of the upper portion of the tract includes passage of catheters to the kidneys and a record of residual urine in the renal pelvis; it also provides specimens for microscopic examination through stained smears and cultures when indicated. This ureteral catheterization together with kidney function tests by phenolsulfonphthalein or indigo carmine, plus retrograde pyelograms, gives a complete picture of the entire urinary tract. It is especially important that a roentgenogram in the vertical posture be made after the catheters are withdrawn.

My associates and I selected 100 consecutive cases of pyuria in 1948 and analyzed them as shown in figure 4.

There were 20 cases with pyuria the only symptom, 52 cases with bladder symptoms added, and 28 cases with symptoms referred to one or both kidneys, with or without bladder symptoms. We took especial interest in the 20 cases of pyuria alone since they are the ones most often treated by the physicians using the various new chemotherapeutic drugs so popular today. A further break-down is shown in figure 5.

Here it is shown that in 9 cases, or 45 per cent of those in which pyuria alone was present with no bladder symptoms, pathologic change was present in the upper part of the urinary tract, and in 7 surgical intervention was required. In only 27 per cent of the cases with bladder symptoms, however, was there a pathologic condition in this area, and in only 8 per cent were major surgical measures required. Furthermore, of the third group, in which definite disease of the upper portion of the tract would be expected, pathologic change was present in only 50 per cent of the cases, and but 18 per cent required surgical treatment.

There are shown, in brief, in figures 6 to 12

Symptoms	Number of Cases
Pyuria alone	20
Bladder symptoms { Pyuria Frequency and burning Pain on voiding Burning on voiding Urgency Difficult urination	52
Upper urinary tract with or without bladder symptoms { Pain in flank Pain in back	28

Fig. 4. Analysis of 100 cases of pyuria

inclusive the history, findings, and surgical treatment in the 7 cases of pyuria alone.

Of the 7 cases, 5 required nephrectomy. In 1 other case of pyuria, not included, there was bilateral nephrolithiasis of the staghorn or dendritic type. This patient's general condition contraindicated anesthesia and major surgery. These cases illustrate the importance of an early complete urologic investigation for a pathologic condition and its eradication. This study, in conjunction with precise bacteriologic data, including the identity of the causative organism and use of the drug or drugs capable of destroying the bacteria found, cannot be overstressed.

Further study was made on 25 cases in which we obtained urine culture. Figure 13 gives the organisms found in order of frequency. It has now become important that urine cultures be obtained so that the drug which is most efficacious may be used. Otherwise, an expensive and non-effective drug may be wasted, or serious results may ensue.

Treatment

A survey of the literature discloses a trend away from the alkaline-acid rotation and towards treatment by drugs only, such as hexamethylenamine, acid sodium phosphate, sulfonamides, mandelic acid, penicillin, streptomycin and at the present moment, a selection of the chemotherapeutic drug or drugs most effective against the particular organism. Now the sulfonamide drugs are used in combination to decrease their toxicity; mandelic acid is combined with methenamine,¹ and such a combination as sulfathiazole and methylene blue enhances synergistic action.²

In the selection of drugs, the offending organism is of first concern. The doctor may believe that it is not feasible to obtain cultures, but he can obtain an uncontaminated bladder specimen for culture and have a report on this from the laboratory. When this is impracticable, sulfathiazole or sulfadiazole and sulfadiazine combined are the drugs of choice, provided they are tolerated. Since all are familiar with these drugs, it is needless to repeat precautions.

Symptoms	Cases	Involvement of Upper Urinary Tract	Major Surgery
Pyuria alone	20	9 (45%)	7 (35%)
Bladder symptoms including pyuria	52	14 (27%)	4 (8%)
Upper urinary tract symptoms plus the two above	28	14 (50%)	5 (18%)

Fig. 5. Analysis of 100 cases of pyuria

CASE 1.—MRS. A. C. J., aged 47

HISTORY	Persistent pyuria for two years; right ureteral calculus removed eight years before
FINDINGS	Right pyelolithiasis
SURGERY	Right pyelolithotomy
RESULT	Cured

Figure 6

CASE 2.—MR. W. C. B., aged 48

HISTORY	General fatigue and pyuria of three or four years' duration
FINDINGS	Right nephrolithiasis with nonfunctioning kidney; chronic prostatitis
SURGERY	Right nephrectomy
RESULT	Cured

Figure 7

CASE 3.—MRS. M. E. D., aged 74

HISTORY	Persistent pyuria for three years
FINDINGS	Right pyonephrosis with nonfunctioning kidney
SURGERY	Right nephrectomy
RESULT	Cured

Figure 8

CASE 4.—MR. E. B. M., aged 60

HISTORY	Pyuria for four years
FINDINGS	Right pyonephrosis with nonfunctioning kidney; left hydronephrosis
SURGERY	Right nephrectomy; left pyeloureteroplasty
RESULT	Cured

Figure 9

CASE 5.—MR. J. W. N., aged 51

HISTORY	Pyuria routine finding; low backache; constipation
FINDINGS	Right pyelolithiasis; chronic prostatitis and prostatic calculi
SURGERY	Right pyelolithotomy
RESULT	Cured

Figure 10

CASE 6.—MRS. N. I. S., aged 56

HISTORY	Pyuria for four years
FINDINGS	Right pyelolithiasis with nonfunctioning kidney; left ureterolithiasis
SURGERY	Left pyelolithotomy; cystoscopy with removal of left ureteral calculus using stone basket; right nephrectomy
RESULT	Cured

Figure 11

CASE 7.—MRS. F. Q., aged 63

HISTORY	Pyuria for several years
FINDINGS	Vesical calculi; right nephrolithiasis
SURGERY	Litholapaxy; right nephrectomy
RESULT	Cured

Figure 12

Figure 14 shows the drug applicable to specific organism.

Different investigators disagree as to the order of choice, but this is a working table applicable to average cases. The order will change with the method of administration. Since, so far, the oral route has not turned out to be practicable for penicillin and streptomycin therapy, the first choice of drug by this route differs. Furthermore, toxicity or sensitivity of the individual patient influences choice.

In the case of the sulfonamides our results have been more satisfactory and uniform by using sulfathiazole or sulfathiazole and sulfadiazine. Sulfacetimide is recommended as more reliable in the *Bacillus coli* group,³ but this has not proved true in our experience. Sulfathaladine^{4, 5} (1 Gm. four times a day for three weeks) and sulfasuxidine have been particularly effective in *B. coli* pyuria. The effect here is apparently twofold: (1) elimination of foci of infection in the intestinal tract, which increases resistance, and (2) the prevention of the escape of organisms into the urinary tract.⁶ Johnson⁵ and his associates found that 0.10 Gm. of sulfathaladine per kilogram of body weight daily for one or two weeks is equivalent to 0.25 Gm. of sulfasuxidine per kilogram daily for one week followed by one-half this dose for the second week.

Mandelic acid is now returning to its deserved position. Campbell⁷ used 10 to 15 Gm. of calcium or ammonium mandelate daily, while Carroll

	Number	Per Cent
<i>Escherichia coli</i>	9	36
<i>Alcaligenes aerogenes</i>	6	24
<i>Aerobacter aerogenes</i>	2	8
Nonhemolytic <i>Staphylococcus aureus</i>	2	8
<i>Pseudomonas aeruginosa</i> (<i>Bacillus pyocyaneus</i>)	2	8
<i>Shigella alkalescens</i>	1	4
Nonhemolytic streptococcus	1	4
<i>Paracolon bacillus</i>	1	4
<i>Proteus morganii</i>	1	4

Fig. 13. Urine cultures—25 cases

Organisms	1st Choice	2nd Choice	3rd Choice
Streptococci	Penicillin	Sulfadiazine	Sulfathiazole
Staphylococci	Penicillin (1 Gm. doses)	Sulfathiazole	Sulfadiazine
<i>Streptococcus faecalis</i>	Mandelic acid (Mandelamine)	Streptomycin (1 Gm. doses)	Sulfadiazine or/and sulfathiazole
<i>Aerobacter aerogenes</i>	Streptomycin	Sulfathiazole	Sulfadiazine
<i>Pseudomonas aeruginosa</i> (<i>Bacillus pyocyaneus</i>)	Streptomycin (1 Gm. doses)	Mandelic acid	Sulfathiazole or/and sulfadiazine
<i>Proteus vulgaris</i>	Streptomycin	Sulfathiazole	Sulfadiazine
Abacterial pyuria	Arsenical (IV)		
<i>Mycobacterium</i> (tuberculosis)	Streptomycin	(Selected cases)	
<i>Escherichia coli</i>	Streptomycin	Sulfathaladine	Sulfathiazole or/and sulfadiazine

Fig. 14. Selective drug therapy

and his co-workers^{8, 9} recommended sodium mandelate (25 cc. of 20 per cent solution) intravenously twice daily. Mandelic acid is almost specific against enterococcus *Streptococcus faecalis*⁷ and is of proved value against *Pseudomonas aeruginosa*, staphylococci and streptococci. Mandelic acid operates only in acid urine; so the hydrogen ion concentration should be kept under 5.5.

The greatest effectiveness of penicillin^{10, 11} is in staphylococcal, streptococcal and gonorrheal infections. The new preparations, because they maintain a prolonged blood level, may be used with good effect in office practice; but the indiscriminate use of penicillin must be condemned. Its potency may be increased by use of caronamide,¹² maintenance of acidity of urine and addition of one of the sulfonamides (sulfathiazole or sulfadiazine). This addition may prevent acquired resistance.

Streptomycin is one of the latest of our antibiotic agents. Its usefulness has been chiefly against the gram-negative bacteria. It is of high worth in the treatment of infections of the urinary tract due to *Escherichia coli*, *Aerobacter aerogenes* (*Bacillus lactis aerogenes*), *Pseudomonas aeruginosa* (*Bacillus pyocyaneus*) and *Proteus vulgaris*.^{13, 14, 15} The effect is increased sixteen times when the hydrogen ion concentration is raised from 5.5 to 8.0¹⁶ (except in the case of urea-splitting organisms). Early large doses, 2 to 4 Gm. daily in divided doses every four to six hours, should be given, for many patients develop resistance to streptomycin. Its use, combined with penicillin and/or the sulfonamides may prevent this fastness.¹⁵ This drug should be given only when the patient is under close supervision, for middle ear disturbances may occur and they may be permanent. Streptomycin should be used in tuberculosis of the urinary tract both preoperatively and postoperatively, but its value, except in surgical cases, remains the subject of experiment.

Lastly, the arsenicals have been used of late in abacterial pyuria, and promising results are reported by Moore,¹⁷ Vassallo,¹⁸ Coutts and Vargas-Zalazar¹⁹ and Hamm.²⁰ Treatment with novarsenobenzol,¹⁷ 0.3 to 0.45 Gm. every four to seven days for four doses, has given more satisfactory results than mapharsen in 0.3 Gm. doses every five days for five doses.²⁰

Summary

All proved pyuria calls for complete urologic study.

In the series of 100 cases here presented there are as many with disease of the upper part of the urinary tract and pyuria alone as there are when definite symptoms pointing to the upper portion of the urinary tract are present.

Eradication of the pathologic condition whenever possible must be carried out before a cure can be expected, with or without chemotherapy.

The drug should be selected for the specific organism present.

The indiscriminate use of modern chemotherapeutic drugs is deplored.

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Discussion

DR. ROBERT J. BROWN, Jacksonville: I enjoyed Dr. Pyle's paper very much. I think the subject was appropriate and the paper thorough.

Pyuria is of primary concern to all of us, and though

it is usually simple to determine the source of pus coming from the urinary tract distal to the bladder, it is not always easy to learn the reason for pus in the bladder or above. Here the cystoscope and the ureteral catheter play an important role, for by their use the pus can usually be traced to its source.

As Dr. Pyle brought out in his paper and Dr. McIver also brought out, persistent or recurrent pyuria should be thoroughly investigated. With improvements in instruments, technic and anesthesia examination may now be done safely. With newer and smaller instruments children of any age may be thoroughly studied without ill effects; in fact they seem to tolerate the procedure better than adults.

Dr. Campbell, in his book on pediatric urology, analyzed 580 cases of chronic infection of the urinary tract. In this series 152 (26.2 per cent) of the patients were cured, 245 (42.4 per cent) were improved, 50 (8.6 per cent) were unimproved, 74 either refused treatment or were lost tract of, and 58 (10 per cent) died. These figures were reported before the later chemotherapeutic and antibiotic drugs were in use, but none the less they are impressive as to the need for early diagnosis and adequate treatment. In congenital defects of the urinary tract, often pyuria may be the only sign, or it may be accompanied by subjective symptoms which may not be relied upon. It is most important in these cases that the disease be recognized early before irreparable damage occurs.

In Dr. Pyle's series, I was impressed with the 20 cases in which the only symptom was pyuria and one fourth

required nephrectomy. I have recently observed similar cases of advanced renal disease in which the patients had been treated for recurrent pyuria, some for many years. I should like to echo his belief that these cases should be investigated early and completely.

DR. T. LEON HOWARD, Denver, Colo.: I am glad to hear this paper being read before general surgeons and practitioners, for these are the men who see these cases first; seldom does the patient get to the urologist during the period of his first symptoms. Consequently, it is up to the practitioners doing general surgery and medicine to recognize the source of the patient's infection and refer the case before the pathologist takes over, as Dr. McIver has so aptly said. Pediatricians are directly responsible for pathologic conditions in children, and it must be made plain to them that their responsibilities are great, for if these conditions in a child are not corrected, the future health of that child will always be jeopardized from this early lack of a correct diagnosis.

Dr. Pyle's paper covered a great deal of work, and I hope it is appreciated. You doubtless do not realize the multitude of examinations that were made in the preparation of this paper. I wish to compliment him on his thoroughness.

The use of our present day antibiotics often produces a sterile urine, but the patient is left with the pathologic condition that was the direct cause of the infection. We must be forever on the lookout to remove that cause and in this way prevent damage that is irretrievable if there is procrastination.

Urologic Consideration of Urinary Incontinence in the Female: Analysis of One Hundred and Twelve Cases

ARTHUR J. BUTT, M.D.*

PENSACOLA

AND

W. E. KITTREDGE, M. D.**

NEW ORLEANS

The principal disorders of urinary control in women are stress incontinence and urgency incontinence. These two types of incontinence are closely related and are often associated in the same patient. A delineation between them is essential, as the proper method of treatment depends upon this differentiation. All too frequently women with incontinence are subjected to surgery, without relief of their symptoms, because of inadequate investigation as to the cause of the incontinence. Incontinence due to great relaxation and/or defects of the supporting structures of the urethra and bladder is a true stress incontinence, and surgical correction is usually indicated; how-

ever, in some cases in which the incontinence is due to mild cystourethrocele there is favorable response to conservative treatment. The urgency type of incontinence, although common, is not often considered when the cause of dysfunction of urinary control is being determined. This type is most commonly due to chronic urethritis and simple cystitis. It is relieved by conservative treatment in the great majority of cases.

An understanding of the anatomy of the female bladder and urethra and the physiology of micturition is essential to a thorough evaluation of incontinence. The adult female urethra is a tubular structure which averages approximately 3.5 cm. in length and accommodates a size 26-28 French sound. From the vesical orifice, the urethra extends downward and forward to the

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meatus which opens in the midst of the vestibule. In this position it is directly anterior to the lower part of the vagina. The histologic anatomy of the female urethra and the relationship of the urethra and trigone to the female reproductive organs are an important predisposing factor to the invasion of disease. The contaminated vaginal secretions offer a constant source of infection to the lower portion of the urinary tract because of the proximity of the external meatus to the vagina. The urethra is lined with squamous epithelium in its outer two thirds and with transitional epithelium which merges with that of the trigone in its inner one third. The paraurethral glands of Skene open on both sides of the external urethral orifice. In addition to these, there are numerous urethral glands which open into the lumen of the canal.

In the normal female the tonus of the vesical sphincter is sufficient to prevent the passage of urine from the bladder. Constant voluntary contraction of the vesical sphincter is, therefore, not necessary for urinary incontinence. With the bladder at rest, the sphincter is firmly closed, but is not in a state of continuous contraction. It contracts actively only when a desire to void is suppressed. If, from its resting, closed state, the sphincter is gradually distended, it will exert a contractive force proportionate to the degree of distention.¹ Active contraction of the wall of the bladder produces relaxation of the urethra, and distention of the urethra causes contraction of the detrusor muscle.² If the urethra is not distended, contraction will not occur; but once it is opened by trigonal action and stretched by fluid passing through it, the muscle tends to close. The loss of this "reactive contraction" mechanism undoubtedly contributes much to the causation of incontinence in the female.¹ The deposition of fibrous tissue in the posterior urethra and neck of the bladder, as a result of chronic infection in this area, is one of the primary causes of loss of reactive contractivity. Also, the presence of inflammatory polyps at the neck of the bladder may interfere mechanically with the activity of the urethral sphincter. Irritation of the urethra may cause relaxation of the vesical sphincter, either directly or indirectly, when the sphincter becomes relaxed as a result of reflex contraction of the detrusor muscle.³ These conditions might explain coexistence or alternation of symptoms of urinary frequency, obstruction and incontinence. Fibers of the reflex arc run through the pelvic and pudic

nerves; consequently, stimulation of these nerves often produces dysfunction of the urethral sphincter. For this reason urinary symptoms frequently occur in patients with pelvic disease.

With urinary frequency there is a frequent desire to urinate, but incontinence does not occur if the desire is satisfied. With urgency of urination there is usually, but not necessarily, an associated frequency. If the desire to void is not satisfied within a short time, urine may be spilled. Urgency may occur with a normal bladder which is abnormally distended, it may be the result of mental influence, or it may be the result of vesical or urethral infection or irritability. In urgency incontinence there is always first the desire to void, while in stress incontinence this desire is not felt. Stress incontinence may result from any cause of increased intravesical pressure which is sufficient to overcome decreased resistance resulting from a defective vesical sphincter mechanism. Urgency and stress incontinence are not infrequently present in the same patient. In such cases the women will, at one time, lose urine because they are unable to reach the toilet soon enough when they feel an irresistible urge to urinate. At another time, they may not realize that they have spilled urine until it dribbles down their legs or their underclothes become wet.

All patients who present the symptom of urinary incontinence require a careful investigation. Examination consists of inspection and palpation of the urethra and pelvis, urinalysis, cystourethroscopic study, and roentgenograms as indicated. A Gram stain should be made of any purulent urethral discharge to exclude gonorrheal urethritis. Culture of the suspected material may be necessary to detect specific infection in some cases. Urethral catheterization is done in all patients to (1) obtain an uncontaminated urine specimen; (2) determine if a stricture is present; (3) determine the presence of residual urine; and (4) determine the capacity of the bladder. Neurogenic lesions as a cause of incontinence must be excluded by appropriate neurologic examination. When an obvious cause of incontinence is not discernible, roentgenologic examination must be made to exclude developmental anomalies or other urologic cause of dysfunction of the bladder.

Irritability of the bladder which results from nonspecific cystitis is a rather common cause of incontinence. The most important causative organisms are the colon bacillus, staphylococcus and streptococcus. These are demonstrated by methy-

lene blue stain, which is done routinely on all specimens. Gram's stain and urine cultures are the diagnostic measures performed when more definitive determination of the organisms is necessary. Intractable urgency incontinence is a frequent symptom in cystitis of tuberculous origin. A thorough search for the tubercle bacillus should be carried out in all patients with symptoms referable to the bladder who have a sterile pyuria or in whom tuberculosis is suspected. Interstitial cystitis (panmural cystitis, Hunner's ulcer, elusive ulcer) has a special predilection for the female. Markedly painful urination which may eventuate in an almost constant urgency incontinence is experienced in many patients with this distressing type of cystitis. This condition should be suspected when there is extremely painful urination, frequency and a sterile urine. The presence of the lesion is confirmed by cystoscopic examination.

When symptoms of diurnal and nocturnal frequency with burning and urgency of urination are present, chronic urethritis (also called nonpurulent urethritis, nonspecific urethritis, or granular urethritis) should be suspected. It is particularly significant that in 95 per cent of such cases, urinalysis gives negative results.⁴ This condition is commoner than is generally realized and is frequently overlooked as a cause of many acute and chronic urinary symptoms.^{4-7a, 8-13a, 14-18} The history and a urinalysis giving negative results usually give a good indication as to the presence of this condition. Introduction of the catheter as a rule reveals an extremely sensitive urethra. The cystourethroscopic picture is that of an infected, granular-appearing posterior urethra and an irregular, inflamed neck of the bladder. The latter is often covered by small cysts and polyps. Frequently, the trigone is injected (trigonitis), and it may be covered by small inflammatory cysts which are superimposed upon the hyperemic mucosa of this area.

Glingar,¹⁰ in 1924, was one of the first to treat incontinence conservatively by cauterizing the neck of the bladder. Later this method of treatment was claimed to be successful by numerous European gynecologists and urologists. Despite their reports, the assumption persisted that incontinence is the result only of mechanical defects of the supporting structures of the bladder and urethra, and that surgery offers the only hope for cure. Recently, however, renewed interest in the conservative treatment of incontinence has been

stimulated by reports of favorable results from the nonsurgical treatment of incontinence in selected cases.^{2, 7b, 13b, 20}

Urologic treatment of incontinence is directed toward relieving cystitis and urethritis, if these conditions are the cause of the disorder. When the urine is infected, a course of chemotherapy or antibiotic therapy is given, and the incontinence is usually relieved by this treatment alone. In all cases of urinary infection there should be a complete investigation of the urinary tract to determine the source of infection. The cystitis of tuberculosis and interstitial cystitis require further studies and special types of treatment which will not be discussed here.

When the diagnosis of chronic urethritis has been established, therapy involves, chiefly, three procedures: (1) irrigation and distension of the bladder; (2) dilatation of the urethra with sounds; and (3) instillation of silver nitrate solution into the posterior urethra. Because of the presence of cicatricial tissue, resulting from chronic infection, it is essential that the urethra be dilated by passage of sounds up to size 28 to 30 French. One should begin with whatever size sound the urethra will comfortably accommodate. If there is decided narrowing of the external urethral meatus, meatotomy should be performed. Silver nitrate is instilled in the posterior urethra by means of a Keyes instillator. Two cubic centimeters of 0.5 per cent solution is used as an initial instillation, and gradually the percentage of the solution is increased with each treatment to a maximum of 2 per cent in cases in which it is tolerated. A series of five to six weekly treatments will usually suffice. The administration of estrogenic hormones to a patient in the postmenopausal period will frequently alleviate the symptoms of incontinence when used in conjunction with the previously described treatment. We have observed that a better local effect results from estrogenic suppositories than from oral or hypodermic administration. In cases of incontinence due to mild cystourethrocele treatment should be conservative at first in order to determine if relief can be obtained by this method. Any existing urinary infection must be eradicated. Local treatment of the bladder and urethra is carried out as outlined for chronic urethritis.

Clinical Analysis

One hundred and seventy-six unselected cases of urinary incontinence, treated at the Ochsner

Clinic and in private practice by one of us (A.J.B.), were analyzed. There were 112 patients in whom incontinence was due to urologic disease (simple cystitis or chronic urethritis), gynecologic disease (mild cystourethrocele), and urologic and gynecologic disease (simple cystitis or chronic urethritis and mild urethrocele). It is this group of patients with which this clinical analysis is concerned. There were 64 patients in whom the cause of incontinence was due to developmental anomalies of the urinary tract, neurologic lesions, cystitis associated with tuberculosis, interstitial cystitis, and gynecologic disease which obviously required surgical correction. This group of cases was excluded from the clinical analysis.

Sixty-six patients or 59 per cent had as a cause of incontinence urologic disease. In 30 patients or 27 per cent, incontinence was due to gynecologic disease. Incontinence was due to both urologic and gynecologic disease in 16 cases or 14 per cent. An analysis of these cases was made in an effort to differentiate clinically between urgency incontinence which was due to pathologic change in the urologic tract and stress incontinence which was due to pathologic change in the gynecologic tract. The cases in which there was a combination of urgency and stress incontinence were analyzed (tables 1, 2, 3 and 4). Patients with urgency incontinence were the youngest group. They had had symptoms the shortest period of time, had the least number of children, and more were childless; also they had the least number of previous operations for relief of incontinence. Those patients with both urgency and stress incontinence had symptoms the longest period of time, were older than the first two groups, had more children and none were childless; in addition, they had been subjected to more previous operations for

the relief of incontinence. Symptoms referable to the bladder were commoner in those with urgency and combined urgency and stress incontinence. Those with stress and urgency and stress incontinence more frequently complained of pain in the lower portion of the abdomen, pelvic pain and backache.

There were 16 cases in which simple cystitis was the cause of urgency and urgency and stress incontinence. Usually treatment of the urinary infection relieved the incontinence; however, in

Table 1.—Comparative History in Urgency, Stress, and Urgency and Stress Incontinence

	Cases Number	Cases Per Cent	Average	Duration of Symptoms, Average in Years	Shortest Duration of Symptoms in Days	Longest Duration of Symptoms in Years
Urgency incontinence	66	59	36	2.9	3	40
Stress incontinence	30	27	44	5.4	3	10
Urgency and stress incontinence	16	14	49	8.9	90	26

Table 2.—Comparative History in Urgency, Stress, and Urgency and Stress Incontinence

	Average Number of Children per Patient	Parents Childless		Previous Operations for Incontinence	
		Number	Per Cent	Number	Per Cent
Urgency incontinence	2	8	12	22	33
Stress incontinence	3.1	3	10	12	40
Urgency and stress incontinence	4.1	0	0	14	87

Table 3.—Comparison of Symptoms in Urgency, Stress, and Urgency and Stress Incontinence

	Frequency		Nocturia		Burning		Urgency	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Urgency incontinence	60	90	56	85	47	71	66	100
Stress incontinence	21	70	7	23	4	13	6	20
Urgency and stress incontinence	14	87	12	75	1	6	15	94

Table 4.—Comparison of Symptoms in Urgency, Stress, and Urgency and Stress Incontinence

	Suprapubic and Pelvic Pain		Backache		Cystitis, Urinary Infection		Hematuria	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Urgency incontinence	40	60	36	55	15	23	20	30
Stress incontinence	26	87	22	73	0	0	0	0
Urgency and stress incontinence	16	100	16	100	1	6	2	13

several cases local treatment of the urethra was necessary to give the patient complete relief of incontinence. Twenty patients with urgency incontinence and two patients with urgency and stress incontinence had hematuria as a symptom, whereas none of the patients with stress incontinence had complained of passage of blood.

Conservative treatment cured 88 per cent of patients with urgency incontinence, improved 9 per cent, and left 3 per cent unimproved. Sixty-three per cent of those with stress incontinence were cured, 10 per cent were improved, and 27 per cent were unimproved. Of those with urgency and stress incontinence, 31 per cent were cured, 31 per cent were improved, and 38 per cent were unimproved (table 5).

Summary and Conclusion

A comparative analysis is made as to symptomatology in 112 patients with urgency, stress, and combined urgency and stress incontinence.

Incontinence associated with frequent, painful and urgent desire to urinate is an urgency incontinence.

Conservative treatment relieved or cured 97 per cent of patients with this type of incontinence. Seventy-three per cent of patients with stress incontinence due to mild cystourethrocele were relieved or cured, and 62 per cent of patients with both urgency and stress incontinence were relieved or cured. In many of these patients, previous surgical measures for the relief of incontinence had been unsuccessful. Conservative treatment of urgency incontinence is discussed.

It is urged that all patients complaining of a significant urinary incontinence be given an adequate urologic investigation before the decision for surgical correction is made.

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Table 5.—Results of Conservative Treatment of Incontinence

	Cured		Improved		Unimproved	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Urgency incontinence	58	88	6	9	2	3
Stress incontinence	19	63	3	10	8	27
Urgency and stress incontinence	5	31	5	31	6	38

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Discussion

DR. LINUS W. HEWIT, Tampa: I certainly enjoyed Dr. Butt's paper and wish to state that all of us can help patients with stress incontinence by dilating the urethra with a sound. The dilation should be started with size 20 F and the urethra dilated to size 28 F. It is a simple procedure and in many patients this alone will bring about a cure.

Multifocal Malignant Neoplasia: Case Report of an Unusual Combination of Unrelated Cancers

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AND

ALPHEUS T. KENNEDY, M.D.

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The coexistence of two or more malignant tumors in the same patient has been noticed from time to time and is of interest not only to the surgeon and to the pathologist but to all students of the cancer problem. Billroth¹ was a pioneer in this subject, as he was in many branches of medicine. His cases of multiple malignant growths, which were the first to be reported, were recorded in 1863. It was necessary that certain requirements be met before this authority considered a case to be proved. He postulated that (a) each tumor must have a different histologic appearance, (b) the tumors must arise in different locations, and (c) each must produce its own metastases.

Warren and Gates^{2a} also studied this subject thoroughly, and they concluded that Billroth's postulates are not always capable of fulfillment. They therefore established the following criteria: (a) each of the involved tumors should present a definite picture of malignant new growth; (b) each tumor should be a distinct entity; and (c) the probability that any one (or more) of the observed tumor loci might be metastatic secondary growth must be excluded.

Other workers support the following criteria of Goetze:³ (a) the tumors must have macroscopic and microscopic structures identical with the established neoplasms of the tissue and/or the organs involved; (b) the probability that one or more tumors are metastases must be excluded with certainty; and (c) metastases may readily confirm the character of one or more of the primary tumors. In their studies at the Mayo Clinic, Hannon,⁴ and Hurt and Broders⁵ supported these criteria.

A review of the literature reveals that multiple cancers occur in approximately 4 per cent of autopsy material from patients who have previously had cancer. In their studies of a significant number of cases, Warren and his associates^{2a, 6-8} approached the problem from the standpoint of incidence and also the various combinations of neoplasms occurring. Some workers have attempted to prove that the presence of a malignant growth predisposes to the development of others. It is our opinion that this point is unacceptable at present and that the occurrence of two or more primary

lesions, concurrently or otherwise, is simply a matter of unrelated coincidence.

The case presented here was observed at the Duval County Hospital and, interestingly enough, seems to fulfil even the rigid postulates of Billroth.¹ At the same time, it is unusual.

The patient in this case had an obvious carcinoma of the breast of the medullary variety, and it had spread to the pectoral muscles, regional lymphatics, lungs, pleura and liver. The second neoplastic growth was a primary adenocarcinoma of the hypophysis, chromophobe cell type, which had spread to the frontal and temporal lobes of the brain.

In discussing pituitary tumors one must consider the histopathology of the pituitary gland. Adenomas develop from either acidophil or basophil cells, but the majority of both benign and malignant growths develop from the chromophobe cells. These cells are nongranular and are not known to have any secretory activity. From a

surgical standpoint chromophobe adenomas are important because often they are slow-growing and recognized on the basis of pressure symptoms. Acidophil tumors cause acromegalic overgrowth, and the adenoma thus reveals itself through constitutional manifestations, long before it is large enough to erode the sella turcica or to cause pressure symptoms. This particular type will sometimes respond to roentgen therapy. Basophil tumors occur more rarely and usually cause few symptoms.

Pituitary adenocarcinoma may conceivably arise from any of the cell types mentioned. The chromophobe variety, however, occurs with the greatest frequency. Microscopic structure is said to vary. Some cell groups grow in solid cords or compact groups of polygonal cells; others take an adenomatous pattern. Often the tumor cells show great variation in size and shape, and exhibit many mitotic figures. While some tumors of this type metastasize distantly, it is involvement of the brain that usually causes death.



Fig. 1.—Lateral view of the left breast showing the inverted nipple and some skin involvement over the tumor.

Report of Case

N. S., a Negro woman aged 56, came to the hospital on Dec. 18, 1946 with a chief complaint of a tumor in the left breast. The tumor had been present for one year. At the onset, the patient felt a nontender mass, and there was some bleeding from the nipple. These symptoms persisted, and the tumor increased slowly in size until the time of admission. There had been a 25 pound loss of weight in the previous six months.

The main points of physical examination were limited to the breast. The left breast was larger than the right and irregular in outline. The nipple was elevated and slightly inverted (figs. 1 and 2). The breast contained a tumor measuring 12 by 10 cm. It was attached to the skin and the fascia. Three small lymph nodes were palpable in the left axilla. There was no evidence of extension to the neck or to the other breast. Roentgen examination of the chest on that date was reported as giving negative results.

On December 31, a radical mastectomy was performed, and the skin was partially closed. Pathologic examination of the surgical specimen revealed medullary carcinoma (fig. 3) with metastasis to the regional lymph nodes and extension to the pectoralis major muscle (fig. 4). The patient was in satisfactory condition following the surgical procedure. The wound on the left side of the chest was granulating and skin graft was being considered when there developed an unexplained hyperthermia. In spite of chemotherapy and supportive measures, the condition of the patient grew steadily worse, and she expired on Jan. 27, 1947.

Postmortem examination revealed numerous small pearl-gray nodules throughout the lungs and pleurae measuring about 5 mm. in diameter (fig. 5). The liver contained several large pearl-gray nodules, the largest of these measuring 9 cm. in diameter (fig. 6). The pituitary gland measured 6 cm. in diameter. It was soft and necrotic (fig. 7). In the frontal and temporal lobes of the brain,

similar soft necrotic areas were found, each measuring about 2 cm. in diameter (fig. 8). Dissection of the brain revealed that these latter lesions were evidently not a direct continuation of the neoplastic mass which had replaced the pituitary.

Summary

In summary, it may be seen that the established facts in this case fulfil the criteria of Billroth.¹ The Army Institute of Pathology kindly reviewed the microscopic pathology. A search of the literature does not reveal a similar case involving the breast and the pituitary gland.

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Fig. 2. — The nipple of the left breast is elevated and inverted, and the tumor with its skin attachment is visualized.

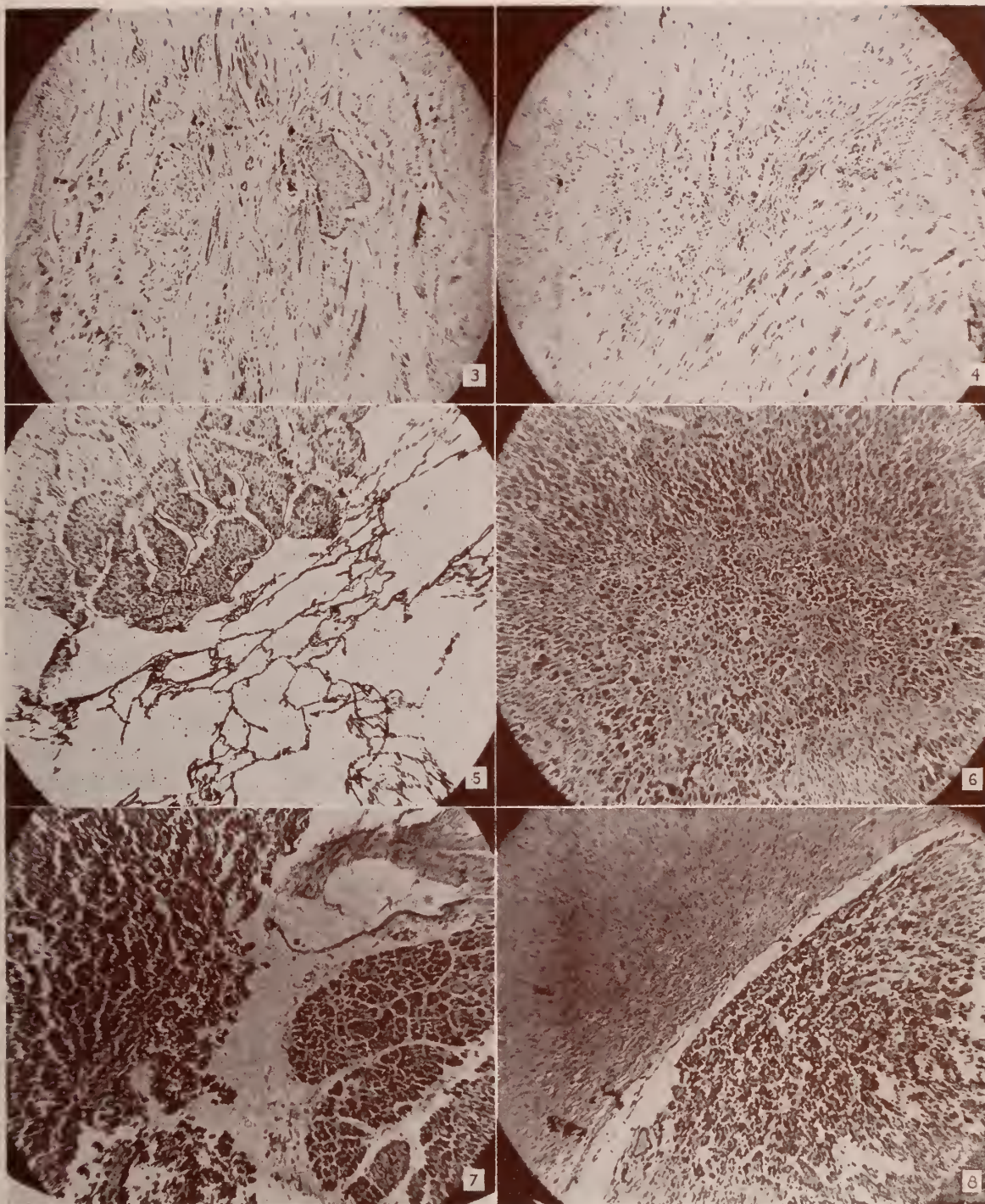


Fig. 3.—Primary medullary carcinoma of the breast.

Fig. 5.—Metastatic extension of the breast neoplasm to the lung.

Fig. 7.—Primary adenocarcinoma of the pituitary gland (chromophobe cell type).

Fig. 4.—Extension of the breast carcinoma to the pectoralis major muscle.

Fig. 6.—Metastatic extension of the breast carcinoma to the liver.

Fig. 8.—Extension of the pituitary adenocarcinoma to the temporal lobe of the brain.

Complications of Anorectal Surgery

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This title, obviously, is certainly not the most pleasant one that could have been chosen for presentation because this subject is seldom discussed and only occasionally written about. It is avoidable doubtless because it naturally points up errors in judgment and technic on the part of the discussor.

Yet, if we proctologists are sincere in our desire to bring about better results in a higher percentage of cases, we must take account of the hazards and pitfalls accompanying our service. A strict inventory will then cause us to consider complications and lead us to create ways and means of reducing and attempting to eradicate them.

All of us realize our human limitations, and even in our fondest dreams, we know we will never attain perfection, but the Oath of Hippocrates, our knowledge of the centuries of honest dealings between physicians and patients and our own deep-seated desires compel us to examine our shortcomings and try ever harder to avoid complications.

Before we detail the complications of anorectal surgery, it is necessary to enumerate the common anorectal operations. They are: hemorrhoidectomy, ulcerectomy, fistulectomy, pruritectomy, papillectomy, adenomectomy, proctotomy, anatomy and repair proctentia.

It is during the performance of these procedures or in giving postoperative care that certain factors arise which create the following complications:

1. Urinary retention (inability to void postoperatively)
2. Fecal impaction
3. Hemorrhage
4. Abscess
5. Fistula
6. Stenosis
7. Delayed wound healing
8. Pruritus

9. Incontinence
10. Recurrence
11. Exacerbation of other diseases

Urinary retention or the inability to void following anorectal surgery, and hemorrhoidectomy in particular, has been a most annoying symptom to both patient and surgeon. It is true that the trend to "Do not plug or pack the anal canal" alone has reduced this complication from almost 100 per cent to approximately 6 per cent. Other factors should be thought of, such as attempting to reduce postoperative ano-perianal edema. It is true that persistent urinary retention which requires multiple catheterizations occurs in those whose ano-perianal tissues are greatly swollen. Microscopic edema is to be expected any time a cell is severed and allowed to remain in the body, but edema that is grossly visible to the eye means an interruption of normal lymph channels to an exaggerated degree. The injudicious use of many clamps for retraction, excessive suturing, and failure to saucerize wounds are the three commonest causes for ano-perianal edema, which is the initiating point for reflex contraction of the neck of the bladder, which in turn causes urinary retention.

Fecal impaction occurs far more commonly than we suppose, and I am sure many patients relieve themselves of this complication by enemas after they leave the hospital following anorectal surgery. A careful history about bowel function on the first postoperative office visit will many times reveal that the patient had a heavy feeling in the rectum after returning home and that going to stool did not relieve the feeling of pressure. This symptom plus a history of liquid stools (not diarrhea or an increase in number) is generally indicative of postoperative fecal impaction.

Impactions develop in some cases whether or not mineral oil or a soft bulk-producing agent is used. I have tried most of the mineral oils, karaya gum, and psyllium seed products and find none of them perfect in eliminating a small percentage of fecal impactions. The best routine seems to be the continuation of general diet throughout the

hospital stay, use of mineral oil daily for fecal emulsification, emphasizing 64 ounces daily water consumption, addition of soft bulk-producing agents between the tenth and fourteenth post-operative days and discontinuation of mineral oil at that time. We instruct patients upon leaving the hospital to take 1,000 cc. saline enemas immediately upon noting any feeling of heaviness or weight in the rectum. In my opinion, fecal impaction and also severe pain at the first post-operative defecation can be eliminated by having all patients take $\frac{1}{2}$ ounce of mineral oil twice daily for five days before the operation. This therapy will emulsify all gastrointestinal contents, and if mineral oil is used immediately postoperatively, the first defecation is usually painless. The daily giving of a phenolphthalein laxative, such as caroid and bile salts tablets, until the first stool will cause greater peristalsis and eliminate straining effort at defecation time.

Hemorrhage is the most distressing of all complications. Roughly it can be divided into the early (immediate) and late (delayed) types. The early type should, theoretically at least, be eliminated by firmly ligating the hemorrhoidal vessels in their cardinal columns internally and by either application of ligature ties or electrocoagulation to the external ano-perianal bleeding points. Delayed hemorrhage is a complication that is going to occur in about 1 in every 200 cases regardless of what type of surgical method is used and in spite of a reported normal bleeding and clotting time preoperatively. The probable reason is that in the process of formation of granulation tissue a large vascular bud either bursts loose from its own growth pressure or is eroded by surface infection or is mechanically abraded by hard stools or straining efforts to defecate. This percentage will, therefore, have to be endured as long as we continue to practice anorectal surgery. In early hemorrhage, our advice is to take the patient back to the operating room and again ligate the bleeding source, rather than to depend on painful packs and the new clotting substances like oxycel or gelfoam, for that is like sending a boy to do a man's work.

Abscess formation is an indictment against us for not observing the principles of open drainage in infected wounds. This means all anorectal wounds should be made flat or saucerized, the edges beveled so as not to undermine the lymphatic bed which is going to be urgently needed;

then drainage zones should be created far enough to the outside to facilitate drainage of the infected exudate which forms around suture material and in the open wounds left inside the anal canal. I realize that the surgeons who use closed or relatively closed hemorrhoidectomy operations will argue this point, and my reply is that I have had abscesses develop in those patients upon whom I have tried closure, and few abscesses have materialized when I have used the popular "open method" types. Incision and drainage of abscesses are naturally indicated when they arise, and the patient should be told to expect fistula formation for that is what will happen in the great majority of these cases.

Fistula complicates anorectal surgery, other than in previous fistulectomy, only because the surgeon has neglected the principles which keep down abscess formation. When fistula recurs, the surgeon should reoperate, find the primary opening, usually on the dentate or pectinate line, and remove it because its reinfection and burrowing out in the new scar tissue of the previous fistulectomy caused the recurrence. Regardless of how one interprets Dr. Claude Tucker's "infected anal glands and ducts" as the etiologic factor in fistula in ano, the original infection occurs in those glands and ducts because of extension of the infection from the dentate line crypts. Overlooking a primary infected anal crypt will lead to fistula recurrence; thus it is demanded that this source be found and removed to prevent recurrence.

Stenosis can be thought of as either a narrowing of the lower part of the anal canal involving the anus, or narrowing of the upper portion of the anal canal involving the rectal mucosa above the dentate line. There, unfortunately, is an occasional case which will be complicated by narrowing of the entire anal canal involving the lower rectal mucosa, anus, and perianal skin. All three varieties of anal stenosis can follow any type of hemorrhoidectomy, whether it is Whitehead's, clamp and cautery, or ligature and excision. Fortunately, stenosis complicates few of the anorectal procedures other than hemorrhoidectomy.

Stenosis of the upper part of the anal canal generally results from an amputation of too much of the rectal mucosa that lies in the grip of the internal sphincter muscle. A modern day hemorrhoidal principle will aid in reducing this complication, and that is "Leave mucocutaneous bridges between excised zones." If the surgeon will ac-

curately define the hemorrhoidal columns and remove only these three columns, then he will have few instances of stenosis of the upper portion of the anal canal.

Stenosis of the lower part of the anal canal can be eliminated by leaving one or more "islands" or "bridges" between excised zones.

Complete stenosis of the anal canal will occasionally occur regardless of whether "islands" are left or not, and even when postoperative use of the surgeon's moulding finger has been employed weekly. It is probable that in these few cases the patient has a fibroplastic diathesis or tendency to keloid formation, as pointed out by Dr. Curtice Rosser of Dallas several years ago.

Postoperative moulding of the anal canal, that is, inserting the index finger into the rectal ampulla by passing through the anal canal, will generally serve as insurance against stenosis. Some surgeons eliminate this none too pleasant weekly task by having the patient insert his own finger into the anal canal or having him use a dilator. Logic seems to rule in favor of the surgeon doing this for it keeps him informed as to the tendency to stenosis, skin bridging, abscess formation, mucous leakage, fecal incontinence (from impaction), and the presence of fecal impaction. The patient should be told that this is "moulding" and not "dilating" for "moulding" is not as uncomfortable.

Delayed wound healing is probably the most annoying of the complications for it saps the vitality of the surgeon as well as the patient. In my practice there have been many causes, the commonest one being the seepage of mineral oil through the sphincters. It took several years for me to realize this fact. It has been reduced in my practice by my having patients discontinue mineral oil on the tenth postoperative day. Hypoproteinaemia and vitamin deficiency, usually pellegra in Dallas, have been next, and the treatment for them is obvious. The undetected early phase of chronic ulcerative colitis, segmental colitis, and unsuspected terminal ileitis has also occurred, which demanded attention before the anorectal wounds would heal. Syphilis, tuberculosis, diabetes, malaria, parasitic infestation and hypothyroidism have been listed by others as delaying factors in anorectal wound healing, but so far these have not occurred in my experience. It is to be constantly kept in mind that incorrectly made anoperianal wounds can also delay healing, and attention to adequate external drainage zones, mak-

ing wounds flat, beveling edges, and preventing skin tab formation will generally aid in normal wound healing.

Pruritus ani, although a symptom and not a disease, complicates proctologic surgery particularly when skin tabs are either inadequately removed or skin edges are not beveled at operation, as they swell and leave skin tabs. These skin tabs prevent normal hygiene and allow sweat, mucus, and inadequately removed feces to accumulate at the base of these tags, and this moisture mechanism brings about itch as a symptom when it had not been noticed previous to anal surgery. Postoperative pruritus ani can also develop from a patulous canal from too generous incision or prolonged packing of anal wounds or from the surgeon being too radical in removing skin and mucosa of the anal canal and leaving a small fibrous canal which leaks normal mucus from the rectal interior. Pruritus can also be avoided by the surgeon having the patient follow a "dry skin regime" for approximately a month following surgical treatment. During this time the new skin adjusts itself, and then the drying out measures can be discontinued.

Incontinence is of two types, mucous and fecal. Mucous incontinence results purely from either a patulous anus or from a fibrosed, stenosed anal canal. These can be eradicated as outlined. Fecal incontinence is a sad complication for its only explanation is that the muscular sphincter apparatus or its nerve supply has been interfered with. In the few cases I have seen, this complication was due to unwise incisions into the fusion point of the deep lamella of the external anal sphincter, internal sphincter, outer longitudinal rectal musculature, and levator ani which is called the "band of continence." Never have I encountered a reason for incision of this deep fusion point; so my deduction as to this complication is that the surgeon creating this distressing condition must not have been aware of his anatomic position at the time the incision was made. Actually there is really small reason for the occasional anal surgeon to be concerned and alarmed about this for this "band of continence" is approximately 1 inch away from the anal verge externally and approximately 1 inch deep to that point. Since this spot is almost never involved in pathologic lesions, one can eliminate this complication. The literature is full of remarks about daily wound packing causing fecal incontinence, but I have my doubts as to

its causing this complication. I have, however, seen mucous incontinence arise from this packing indiscretion; so let us not pack anorectal wounds daily.

Recurrence is probably the most embarrassing of all complications for who of us would fail to blush when the patient asks, "Well, Doctor, isn't that what you operated for?"

Internal hemorrhoidal recurrence can be prevented by adequate excision of all the varicose vein bed. In order to feel secure about this, I make it my custom to electrofulgerize the bed after the ligature has been applied to the superior pole and the hemorrhoid removed with sharp dissection. It is my belief that all of the endothelial-lined vascular bed will then be eroded and complete fibrosis without intermingled vascular buds will take place, leaving no tissue present to become varicosed in later years.

Recurrence of an anal fistula can be prevented by proper demonstration of the primary opening of the fistula on the dentate line and its removal. Much has been made over adequate removal of the tract, external orifice and "off-shoots," but recurrence is dependent upon whether or not its starting cryptic infection is removed. In spite of textbook remarks about not using dye injection in fistulous tracts to demonstrate internal orifices, I think it is wise and prudent. The average surgeon cannot always be sure what is fistulous tract and internal opening and what is not when dye has not been used. Allow me to suggest the use of hydrogen peroxide in the external orifice first, and if it fails to bubble through the internal or primary fistulous opening, then use dye to stain as much of the tract as possible before dissection is begun from outside to inside. If peroxide bubbles through the dentate line cryptic orifice, then dye is not necessary, and a certain amount of "muss" is eliminated. The silver probe can then trace out the tract, and the surgical procedure may begin. If methylene blue is used, I suggest spirits of ammonia to cleanse the field of the bluish discoloration. I know of no one else who uses ammonia in this fashion, but I can assure you it will not damage tissue or interfere with healing. In case the internal orifice cannot be penetrated or outlined by peroxide or dye, it is wise to palpate the "cord" thoroughly and use Goodsall's rule (which should be called Salmon's rule) as an operating guide. It says any opening in the anterior

half of the perianal circumference not over an inch from the anal verge has a tract leading directly into the crypt on the dentate line, and that any opening in the posterior half of the perianal circumference has a curved tract leading into the anal canal and will open into the midline posterior commissure anal crypt. Furthermore, any anterior opening further than 1 inch from the anal verge probably has a curved tract and leads posteriorly to open on the dentate line as posterior fistulas do. It is possible to reduce fistulous recurrences if one waits until the acute abscess and cellulitis have just resolved and then operates. In most of these instances the primary opening is still patulous and easily demonstrated. It is unwise to attempt fistulectomy months or years after its last abscess or while it is latent for in these cases it is difficult to demonstrate the primary cryptic orifice.

Recurrence of anal papillomas (hypertrophic anal papillae) can be prevented by electrofulguration of the base after sharp dissection removal for microscopic study.

Recurrence of rectal adenomas can be prevented by observing the same technic as for anal papillomas.

Recurrence of anal fissures and ulcers can be prevented by incising the smooth muscle band or "bar" just under the ulcer bed. It is erroneously called the external anal sphincter, but if the surgeon will resort to biopsy at the time of incision, he will find it is smooth muscle and not skeletal muscle, which it would have to be if it were external anal sphincter.

The last complication to be discussed is that of anal surgery causing an exacerbation of other diseases dormant prior to surgery. Unfortunately we have had six peptic ulcer hemorrhages in the first few postoperative days and have had innumerable cases of exacerbation of malarial chills, particularly in soldiers who had contracted malaria in the Southwest Pacific. These cases occurred during my military service in World War II. Exacerbations of diarrhea in patients with latent amebiasis and chronic ulcerative colitis have happened enough to cause questioning of every patient preoperatively as to whether he has had known diarrheal diseases or had occasional unexplained diarrhea. These cases deserve stool cultures and smears and double contrast barium enema checkups before anorectal surgery is advised.

Conclusion

In closing, it is obvious that many of the points have been superficially discussed because of limitation of time. It is hoped that this recital of the complications of anorectal surgery will give all of us new impetus to reduce the rate of complication. This renewed interest will not only be a

boon to the individual patient, but will serve its purpose in raising proctologic surgery to a level where the candidate for this type of surgery knows that the chances are good for an excellent result, with little suffering and a smooth convalescence.

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ABSTRACTS OF MEDICAL ARTICLES

ALLERGY AND PSYCHONEUROSES. By Frank C. Metzger, M.D. *J. Nerg. & Ment. Dis.* 109:240-245 (March) 1949.

Noting the infrequent reference in the literature to allergic manifestations observed in conjunction with emotional factors, the author, from experience in his practice, finds the weight of evidence favoring the view that both psychoneurosis and allergy are complicating factors with neither one causing the other. He reports 2 cases of a situation neurosis complicating an allergic condition.

In 65 patients ranging in age from 6 to 19 years, all suffering from asthma, hay fever or hives beginning in September with remissions in June, he obtained a history of fear, frustration and disappointment engendered by their school work. He observes that in such children, and adults as well, the maladjustments are not basic causes of the allergic manifestations, but rather are important aggravating factors. The need for adjustment therefore requires study and correction of their capacity to meet situations; otherwise, they should be kept well within the limits of their lessened ability.

In his opinion, the clinical picture presented by many allergic patients is clouded by psychoneurotic manifestations; many reactions from medicines and hyposensitization treatments are on a basis of fear, not of allergy; and many allergic seizures not explainable on a basis of increased exposure to allergens can be explained on the basis of a complicating emotional experience. A neurosis complicating allergy requires recognition and treatment, he points out, and he observes that the allergist needs the help of a good psychiatrist more often than that of all the other specialists combined.

TREATMENT OF ACUTE BARBITURATE POISONING WITH PICROTOXIN AND METRAZOL. By D. G. Stanus, M.D., and C. F. Roche, M.D. *South M. J.* 41:1052-1055 (Nov.) 1948.

In view of the growing popularity of the use of barbiturates as a suicidal agent and a mortality rate somewhere between 5 and 7.3 per cent, the authors report a case and discuss therapy. They describe the mode of action of picrotoxin and their plan of treatment, and concur in the opinion of most investigators that this drug remains the analeptic of choice because of its sustained effectiveness. The amount of picrotoxin necessary for adequate treatment will vary with the individual case, they observe, and will be governed by the type of barbiturate, the amount taken, and the time elapsed before treatment. "Metrazol," they add, is an aid because of its immediate action.



THE FATE OF THE LIVING VIABLE BABIES IN EXTRAUTERINE PREGNANCIES. By Max Suter, M.D., and Celeste Wichser, M.D. *Am. J. Obst. & Gynec.* 55:489-495 (March) 1948.

In a comprehensive study the authors reviewed all available literature on extrauterine pregnancies resulting in viable, living babies, tabulated 41 cases reported since 1930 to supplement those previously summarized, and added 4 cases from Charity Hospital of Louisiana at New Orleans. They concluded that approximately one fourth of all extrauterine pregnancies diagnosed after the fifth month of gestation will result in viable, living babies. Of these infants, about one third will have major or minor deformities including those incompatible with life, and about one half will survive eight days or more.

COMBINED EXTRAUTERINE AND INTRAUTERINE PREGNANCY. By John P. Michaels, M.D. *Am. J. Obst. & Gynec.* 57: 717-723 (April) 1949.

The four instances reported of the unusual obstetric complication of combined extrauterine and intrauterine pregnancy, defined as connoting the existence of simultaneous pregnancies, were all that a search of the records of the Charity Hospital of Louisiana for the last ten years revealed. It is noted that the ratio of coexistent ectopic intrauterine pregnancy to ectopic pregnancy there during that period was approximately 1 to 100.

At the time of operation for an ectopic gestation, in the author's case (case 1) the combined pregnancy was correctly diagnosed; and in another case (case 2) it was suspected. In both cases the corpus luteum was unfortunately sacrificed. In case 1 a living child was delivered at term by cesarean section, while in case 2 abortion occurred twenty-four days postoperatively. It is suggested that in such instances substitution hormonal therapy should be instigated and maintained at least to the twenty-fourth week. In approximately 25 per cent of the cases reported in the literature, one or occasionally both fetuses continued to term.

Factors recommended for reducing the reported high maternal mortality are: (1) more widespread use of cul-de-sac puncture as an aid in the early diagnosis of ruptured ectopic pregnancy; (2) avoidance of removal of the placenta of the abdominal twin; and (3) liberal and prompt use of whole blood and plasma in the emergency stages.

OBSERVATIONS ON VARIATIONS IN REACTIVITY IN A CASE OF ALLERGY TO PENICILLIN. By Joseph Farrington, M.D., F. A. Dickersman, M.D., and W. L. McGowan, M.D. *Ann. Allergy* 6:30-32 (Jan.-Feb.) 1948.

Wide variation in the degree of hypersensitivity to penicillin may be observed in patients under repeated or prolonged observation. The correlation of hypersensitivity reaction, cutaneous testing and penicillin therapy may be demonstrated. It is observed that in grave emergencies advantage may be taken from the demonstration of periods of relative anergy to this drug for therapeutic action. A case is reported which illustrates the variations in reactivity which may be observed and the advantage which may be taken from these observations for treatment.

LYMPHOID EUSTACHIAN SALPINGITIS: ITS EFFECT ON TUBAL PATENCY; SELECTIVE CRITERIA FOR NASOPHARYNGEAL IRRADIATION. By J. Brown Farrington, M.D. *Arch. Otolaryng.* 48:221-228 (Aug.) 1948.

In recent years, lymphoid obstruction of the eustachian tube has been successfully treated with the nasopharyngeal application of radium or radon, relieving recurrent otitis media and restoring hearing when the deafness has been produced by lymphoid obstruction. This form of office treatment has been abused and often indiscriminately employed. Using the mercurial manometer, the author determined specific criteria which establish the indications for the use of radium therapy and stated that the nasopharyngeal radium applicator is indicated only in those cases in which there is central lymphoid obstruction of the eustachian tube. He performed tubal pressure studies on 100 diseased eustachian tubes to determine the incidence of central and peripheral obstruction. The statistical data of these studies form the basis of this article. Also, the author discusses the differential diagnosis of lymphoid eustachian salpingitis from other abnormalities of the eustachian tube and other types of deafness in which the nasopharyngeal applicator is not indicated.

THE IMMEDIATE URTICARIAL REACTION TO INTRADERMAL TESTING IN PENICILLIN HYPERSENSITIVITY. By Joseph Farrington, M.D., and Joseph Tamura, Ph.D. *J. Invest. Dermat.* 10:421-424 (June) 1948.

An immediate erythema-edema reaction to intradermal testing with crystalline penicillin G and K elicitable in sensitized individuals is described. It consists of an accentuation of the original injection wheal manifested by a slight central edema, spreading of erythema with pseudopodia and red areolas of varying intensity. This immediate reaction appears in from two to five minutes, attains a diameter of 3 to 6 cm. (or more) within ten to twenty minutes, usually recedes within an hour, and frequently is intensified in six to eight hours. The authors originally regarded this reaction as a manifestation of primary irritation from penicillin or its impurities, but experience with the purer crystalline products in dilutions as low as 2.5 units per 0.1 cc. convinced them that this reaction is an indication of specific allergic urticarial hypersensitivity. Some clinical applications of this reaction are described.

ADRENAL CORTICAL TUMOR ASSOCIATED WITH CUSHING'S SYNDROME, REPORT OF A CASE WITH METABOLIC STUDIES AND REMARKS ON THE PATHOGENESIS OF CUSHING'S SYNDROME. By Edwin J. Kepler, M.D., Randall G. Sprague, M.D., O. Theron Clagett, M.D., Marschelle H. Power, Ph.D., Harold L. Mason, Ph.D, and H. Milton Rogers, M.D. *J. Clin. Endocrinol.* 8:499-531 (July) 1948.

A case of adrenal cortical tumor is reported and the metabolic studies accompanying it are described, primarily because of their bearing on the pathologic physiology of Cushing's syndrome, a term used here to refer only to the clinical picture emphasized by Cushing. There were present in this case the clinical features of Cushing's syndrome, including hypertension and hypokalemic, hypochloremic alkalosis. Urinary excretion of both 17-ketosteroids and estrogenic substances was increased to abnormally high levels, and the beta fraction of the urinary 17-ketosteroids was increased. Removal of the tumor resulted in remission of symptoms, which reappeared with its recurrence. Temporary and incomplete remission followed removal of the recurrent tumor, but the symptoms returned with recurrence of the tumor and the appearance of metastatic lesions in the lungs.

At necropsy the following significant observations were made: the anterior lobe of the pituitary body contained two small chromophobe tumors; Crooke's changes were found to be present in the basophilic cells of the anterior lobe; the hypothalamus appeared normal; the tumor had recurred locally and had metastasized to the lungs; the contralateral adrenal cortex was found to be atrophic; although the patient had osteoporosis, the parathyroid bodies appeared to be normal; and the endometrium presented evidence of an apparent absence of progestational effects. The immediate cause of death was a bleeding duodenal ulcer.

A large quantity of urine was collected before operation, and the various steroidal compounds isolated and identified are enumerated.

Metabolic studies were conducted before the first operation and shortly thereafter. Under the conditions employed, the over-all nitrogen balance before operation was negative. Creatine was present in the urine. Potassium was lost from the body and sodium was retained when the potassium content of the diet was kept at a low level.

Administration of potassium chloride tended to correct the alkalosis, the negative balances for potassium and nitrogen and the positive balance for sodium. After removal of the tumor, nitrogen, sodium, potassium and chloride all were retained in large amounts, and creatinuria practically disappeared. The amount and pH of the urine decreased postoperatively. The metabolic data suggested that the functioning adrenal tumor caused loss of muscle and deposition of fat and that its removal was followed by loss of fat and deposition of muscle.

The pituitary versus the adrenal theory of the pathogenesis of Cushing's disease is discussed, and clinical and experimental methods which might eventually prove helpful in establishing or refuting one or the other of these theories are suggested.



NASAL SINUSITIS: EVALUATION OF SULFONAMIDES AND PENICILLIN IN ITS TREATMENT. By A. R. Hollender, M.D., F.A.C.S. *Eye, Ear, Nose & Throat Monthly* 27:414-419 (Sept.) 1948.

A review of the entire subject of the treatment of nasal sinusitis with antibiotics and sulfonamides is presented with the following conclusions:

Penicillin and the sulfonamides are effective only under certain circumstances, and then only as an adjunct to orthodox therapy. Chemotherapy in acute sinusitis probably is effective in shortening the course of the disease and minimizing or avoiding complications, if the infection is due to the drug-sensitive organisms. Convincing proof of the superiority of medicated solutions over isotonic solution of sodium chloride, commonly employed for sinus lavage, is still lacking. For chronic sinusitis penicillin and the sulfonamides, in themselves, irrespective of their methods of administration, are insufficient to produce a cure, but they may prove a valuable aid to indicated nonsurgical or surgical measures.

Although aerosol penicillin represents a definite advance in the administration of this drug for certain infections of the respiratory tract, the method may prove hazardous if employed indiscriminately, and especially before a correct bacteriologic and clinical diagnosis has been made. The sulfonamides and penicillin have certain definite limitations which must be understood if one is to explain scientifically why these preparations often fail to produce successful end results in acute and chronic sinusitis.

TREATMENT OF TRICHOMONAS VAGINALIS WITH TYROTHRIN. By C. Gordon Johnson, M.D., F.A.C.S., J. William Douglas, M.D., and Ruth Y. Mayne, M.S. *Am. J. Obst. & Gynec.* 56:184-186 (July) 1948.

Tyrothricin in the form of an acid suppository was used in the treatment of *Trichomonas vaginalis* occurring in a group of patients observed in the Obstetrical Clinics of the Charity Hospital of Louisiana at New Orleans. A similar group was treated with an acid suppository that did not contain tyrothricin. Treatment was carried out exclusively by the patient. The two main objectives of the study were to determine the value of tyrothricin in treating *Trichomonas vaginitis* and to determine the value of treatment by self medication.

The results indicated that this therapy is not successful. This antibiotic, in suppository form, was not as effective as most common methods now in use. It is concluded that this outcome may perhaps be explained by the fact that all treatments were carried out by the patients themselves and that better results could possibly have been obtained if the therapy had been continued longer. A large number of patients complained of considerable vaginal burning and irritation from both acid tyrothricin and acid control suppositories.



THE LUMBOSACRAL ARTICULATION, A ROENTGENOLOGIC AND CLINICAL STUDY WITH SPECIAL REFERENCE TO NARROW DISC AND LOWER LUMBAR DISPLACEMENT. By Ernest A. Brav, M.D., Howard A. Molter, M.D., and Wendell J. Newcomb, M.D. *Surg., Gynec. & Obst.* 87:549-560 (Nov.) 1948.

In view of the continued difference of opinion relating to the importance of narrowed fifth lumbar disk and displaced fifth lumbar vertebra in the etiology of backache and sciatic pain, a series of 500 roentgenograms was studied for the purpose of establishing the incidence of these conditions. The 181 patients showing these changes on the roentgenogram were then studied clinically to determine the importance of these roentgenographic changes in the light of their principal complaints and significant physical findings. For comparison, the clinical findings of the remaining 319 patients were reviewed.

Narrowed fifth lumbar disk was demonstrated in 26.4 per cent of the 500 roentgenograms fo-

cused over the lumbosacral joint. posterior displacement of the fifth lumbar vertebra was present in 10.2 per cent, anterior displacement of the fifth lumbar vertebra was present in 5.0 per cent, and there was displacement of the fourth lumbar vertebra in 3.0 per cent. The incidence of back and leg pain in the 181 cases in which these changes were noted was not significantly greater than the incidence of these complaints in the other 319 cases. Although clinical diagnoses in the two groups were almost identical, a considerably higher incidence of lumbosacral arthritis was noted in patients with narrow disk or lower lumbar displacement.

The authors were of the opinion that narrowed fifth lumbar disk and displacement of the lower lumbar vertebrae are clinically significant only in that these conditions place additional strain on an already mechanically vulnerable lumbosacral joint. They concluded that the weight of evidence seems to indicate that in most instances narrow fifth lumbar disk and lower lumbar displacement are in themselves not the cause of low back and sciatic pain, the presence or absence of this pain depending almost entirely upon the integrity of the surrounding muscular and ligamentous structures.



INJURIES TO RIGHT THIGH, HIP, AND RECTUM, RESULTING IN INTRAPERITONEAL AIR AND ABSCESSES OF THIGH. By Frederick H. Bowen, M.D. *Transactions of the Association of Seaboard Air Line Railway Surgeons for 1948.*

A case is reported in which there was severe crushing contusing trauma to the right thigh and the right hip and the buttock. This resulted in a laceration extending into the right ischiorectal space, a fracture of the right anterior superior iliac spine and a rupture of the right vastus lateralis muscle. Intraperitoneal air, the origin of which was in question, was demonstrated by several roentgenograms.

Subsequently, there developed abscesses of the right thigh, which were drained. The severe shock which the primary injury occasioned was treated by plasma and morphine. The hypoproteinemia which occurred was treated by blood and amino acids. A questionable episode of pulmonary embolism was treated by Pitkin's heparin menstruum and dicumarol. The patient made a good recovery and returned to his regular work.

INVOLUTIONAL MELANCHOLIA AND CONVULSIVE THERAPY. By I. Leo Fishbein, M.D. *Am. J. Psychiat.* 106:128-135 (Aug.) 1949.

This study presents a comparison between two groups of patients with involutional melancholia in the preshock and postshock eras treated at the Institute of Living (The Neuropsychiatric Institute of the Hartford Retreat) at Hartford, Conn., between July 1, 1935 and Dec. 31, 1937; and between Jan. 1, 1945 and June 30, 1947.

Since there are about 15,000 to 20,000 cases, approximately 3 to 4 per cent of all mental illnesses in this country, it is important to compare the statistics of recovery and improvement with and without convulsive therapy, the treatment of choice. Involutional melancholia is the commonest manifestation of the mental disturbances of the involutional period, in women between 40 and 55, in men between 55 and 65 years of age. The mean age was 53.2 for men and 50.1 for women.

The classical electric machine (Rahm) and the I.O.L. Liberson brief stimulus machine were used. Also metrazol was administered intravenously. Curare was used to lessen the severity of convulsions. Complete examinations, laboratory tests, roentgenograms of the chest and spine, electrocardiograms and electroencephalograms were obtained prior to convulsive treatment. Contraindications noted were cardiovascular diseases, malnutrition and organic brain diseases as well as many others.

The prepsychotic history presents a rigid seriousness and conscientiousness with many restrictions of instinctual life. The future is morbid and ominous with self reproaches for guilt and sinfulness for any pleasures enjoyed. There is the distinct triad of obstinacy, parsimony and perfection. Warning signs are fears, irritability, impulsive anger, intolerance, suspicions, obsessions and anxieties. The patients were anal-erotic, chronic pill takers with many gastrointestinal complaints and trick diets, prudish, vulnerable to psychic and environmental trauma. Many showed physiologic involutional factors as flushing, headaches and gonadal hypofunction.

The total number of fractures after treatment of 113 patients was 8, four of the dorsal spine D3 to D6, and four of the extremities, humerus and scapula. Associated therapy included hydrotherapy, organotherapy and occupational education therapy. Recovery rates reported by others varied from 50 to 90 per cent; in our series the rate was about 90 per cent.

The results in 61 cases of involutional melancholia occurring during the 1935-1937 period, prior to convulsive therapy, are compared with those in 347 cases in which convulsive therapy was employed during the 1945-1947 period. In melancholia cases the patient received 10.8 treatments on an average; paranoid cases, 16.2, and mixed cases, 11.8. The average hospital stay was one and one-half years in the preshock era as compared to six months with convulsive therapy. Evidence indicates that the shock-treated group left the hospital in one-third the time and in better condition than the nonshock group. The improved and increased ancillary therapies also contributed to the results in this investigation.



FAILURE OF THE UROGENITAL UNION. By Louis M. Orr and (by invitation) Joseph C. Hayward and A. Fred Turner, Jr. *J. Urol.* 60:147-152 (July) 1948.

The embryologic development of the urogenital system up to the point of separation into the urinary and reproductive systems is reviewed. A case of unilateral cryptorchidism is reported in which the unusual operative findings included not only failure of union of the testis with the epididymis but also failure of union between the vas deferens and epididymis. A review of the literature revealed no similar instance of embryologic maldevelopment.



THE PROBLEM OF MALIGNANT HYPERTENSION AND ITS TREATMENT BY SPLANCHNIC RESECTION. By Max M. Peet, M.D., and Emil M. Isberg, M.D. *Ann. Int. Med.* 28:755-767 (April) 1948.

In this study of 143 cases of malignant hypertension with treatment by splanchnic resection, the findings suggest that surgical treatment offers some hope to victims of this usually rapidly fatal disease. In this series, the age range was from 14 to 57 years, with 63 per cent of the patients 40 years or older. Sixty-two per cent were men, and 65 per cent of the deaths were among men. The blood pressure levels were high; headache, visual disturbance and dyspnea were the commonest complaints; and constitutional involvement was extensive, organic heart disease in 91 per cent, impaired kidney function in 84 per cent, and cerebrovascular accidents in 20 per cent.

The operative mortality was 10 per cent, but in a disease so deadly, the 20 per cent chance of

prolonged survival was regarded as probably worth the high operative risk. The five year survival rate was 21.6 per cent. In all living patients receiving a fundusoscopic examination five years and more after operation there was no evidence of papilledema.

If splanchnic resection can be performed early, before heart disease has occurred, the outlook is favorable, for in 11 out of 13 cases of the series the patient was living five to twelve years after operation. In cases with survival of five years or more, improvement in the electrocardiogram and decrease in the size of the heart are possible. Once renal function becomes moderately or markedly impaired, however, splanchnic resection is futile, and it is likewise useless when cardiac enlargement varies greater than 50 per cent above predicted normal.

In the opinion of the authors, malignant hypertension, once the diagnosis is established, constitutes an indication for splanchnic resection, provided deterioration, which is rapidly progressive from week to week, has not advanced to the constitutional extent where surgical therapy has proved unavailing.

STUDIES OF THE ACUTE DIARRHEAL DISEASES. XVIII. EPIDEMIOLOGY. By Albert V. Hardy, M.D. (Now Director, Bureau of Laboratories, Florida State Board of Health) and James Watt, M.D., Surgeon, United States Public Health Service. Pub. Health Rep. 63:363-378 (March 19) 1948.

A study of the epidemiology of the acute diarrheal diseases in New Mexico, Georgia, New York and Puerto Rico revealed that the recent reported mortality from these diseases varied from more than 400 to less than 5 deaths per 100,000 population per annum. Culture was positive for *Shigella* in 75 per cent of the children who died from diarrheal diseases in New Mexico and Georgia. The discovered morbidity rates from these infections were comparatively low when reported cases were considered, but were high when intensive case-finding procedures were used; the morbidity from culture-negative diarrheal disorders varied similarly.

Subclinical shigellosis was identified frequently. In infants and young children *Shigella* infections were often serious or fatal; in older children the clinical attacks were milder, and there were many subclinical infections; in adolescents and adults the attacks were most commonly subclinical.

The total attack rates, including clinical and subclinical infections, were relatively constant from ages 1 to 9 years and at a higher level than those for infants, adolescents and adults. There were only minor variations in incidence by sex. Household attack rates were high, and varied inversely with the general incidence of diarrheal disease in the population group.

The incidence of these diseases was high in summer and low in winter. Cases of acute diarrhea due to *Shigella* in the general population occurred chiefly as isolated infections, unrelated to other manifest sources. There was strikingly little evidence that these enteric infections were disseminated by water, milk, or other food. Finger contamination and relatively direct person-to-person spread appeared to be chiefly responsible for the dissemination of these infections in institutional and military groups.

STUDIES OF THE ACUTE DIARRHEAL DISEASES. XIX. IMMUNIZATIONS IN SHIGELLOSIS. By Albert V. Hardy, M.D. (Now Director Bureau of Laboratories, Florida State Board of Health), Thelma DeCapito, Assistant Bacteriologist, Public Health Service and Seymour P. Halbert, M.D., Assistant Surgeon (R), Public Health Service. Pub. Health Rep. 63:685-688 (May 21) 1948.

In view of conflicting opinions regarding the value of *Shigella* vaccines, investigation was made over a period of twenty months in institutions for the mentally ill or defective in New York and Illinois where there was a high endemic incidence of *Shigella* infections. The practical significance of adjuvants was examined, and it was decided to test the efficacy of large doses of vaccine given in saline.

The evidence accumulated strongly indicated that the present *Shigella* vaccines given parenterally are ineffective in the prevention of naturally occurring *Shigella* infections. The significance of booster inoculation and/or revaccination six to eight months after the initial treatments was studied, and there was no suggestion that the second inoculations had better responses than those which followed the first series. It was concluded that present vaccines administered parenterally have no significant value in the control of clinical or subclinical *Shigella* infections.

STUDIES OF THE ACUTE DIARRHEAL DISEASES.
XX. FURTHER OBSERVATIONS OF CHEMOTHERAPY
IN SHIGELLOSIS; THE EFFICACY OF STREPTOMYCIN
AND SULFACARZOLE. By Albert V. Hardy, M.D.,
Director, Bureau of Laboratories, Florida State
Board of Health, and Seymour P. Halbert, M.D.,
Assistant Surgeon (R) Public Health Service. Pub.
Health Rep. 63:790-792 (June 11) 1948.

This study reports response to streptomycin and sulfacarzole therapy in a series of 37 cases of infection with *Shigella* (Flexner type Z) occurring in inmates of an institution for the mentally defective in New York State, who ranged in age principally from 5 to 15 years and were almost all male.

From examination of the culture specimens it was clearly apparent that streptomycin given orally, four doses daily in sweetened milk over a period of three days, had a profound effect on the intestinal flora. The nonpathogens as well as the *Shigellae* rapidly decreased in number during the therapy, which consisted of 3 million units in each of 20 cases and 6 million in each of the remaining 17 cases. In cases in which the disease was due to sulfonamide-resistant strains of *Shigella*, the infection responded as readily to the streptomycin as did that caused by sulfonamide-sensitive strains. No significant toxic reactions to this drug were noted.

Sulfadiazine was substantially more effective than the poorly absorbed compound sulfacarzole, which had the weakness of other products of this type, response being slow. The sulfacarzole, 8 Gm. daily, was administered in four doses and was continued for four days; sulfadiazine, 4 Gm. daily to children, was used similarly. As in preceding studies, the reaction to sulfadiazine was highly satisfactory.

It was concluded that streptomycin may be considered for *Shigella* infections which are resistant to sulfonamides and that the frequency of recurrences would probably be decreased by prolonging the period of treatment.

STUDIES OF THE ACUTE DIARRHEAL DISEASES.
XXI. SALMONELLOSIS IN FLORIDA. By Mildred M. Galton, Bacteriologist, and Albert V. Hardy, M.D.,
Director, Bureau of Laboratories, Florida State
Board of Health. Pub. Health Rep. 63:847-851
(June 25) 1948.

This report covers five years of observation on the occurrence of salmonellosis in Florida. In all, there were 746 isolations of 48 types of *Salmonella*, exclusive of *S. typhi*. The findings are summarized to aid in providing more adequate knowledge of the prevalence and distribution of these infections.

Of the 81,174 fecal specimens submitted for culture during the five year period, 510 were positive for *S. typhi* and 746 were positive for other types of *Salmonella*. The types found to occur most frequently in Florida were: *S. anatum* (14.4 per cent of all), *S. derby* (9.6 per cent), *S. oranienburg* (8.8 per cent), *S. newport* (8.9 per cent), and *S. typhi* murium (8.0 per cent). Almost all (98.5 per cent) of the *Salmonella* isolated exclusive of *S. typhi* were those considered to have animals as their natural host. Seven types not previously isolated were found. These were described by Edwards and his associates and given the names *S. florida* (2), *S. inverness* (3), *S. pensacola* (4), *S. miami* (5), *S. tallahassee*, *S. daytona* (6), and *S. luciana* (7). Three of these, *S. inverness*, *S. pensacola* and *S. daytona*, were encountered once only. *S. miami* was the one new type which was found frequently. It was isolated 53 times, but 26 of these positives were obtained in one outbreak of gastroenteritis involving 60 persons in Miami in May, 1944. This organism was isolated also from pickle served in a restaurant in which the affected individuals had eaten. The remaining isolations came from scattered localities.

The fecal specimens examined came largely from food handlers. Most of the isolations were from apparently healthy persons. Follow-up examinations were submitted on individuals found positive. The data suggest that the carrier state is relatively transient. Repeat positives were uncommon and the longest period over which one person was found to harbor one type of *Salmonella* (other than *S. typhi*) was four and one-half months. Multiple types were occasionally found from the same person.

Geographically the various *Salmonella* types were scattered widely. The evidence did not suggest that there were foci of infection with the different types. The explanation and significance of these widely distributed infections, the authors concluded, clearly warrant detailed investigation.

NEGATIVE RESULTS OF TOCOPHEROL THERAPY IN CARDIOVASCULAR DISEASE. By Charles K. Donegan, M.D., Addison L. Messer, M. D., Edward S. Orgain, M.D., and Julian M. Ruffin, M.D. *Am. J. M. Sc.* 217:294-299 (March) 1949.

A study is reported in which an attempt was made to evaluate by laboratory tests and clinical examinations the effect of tocopherol therapy in selected types of cardiovascular disease. In the series of 21 cases, the patients were kept under observation from five to twenty months; 7 had hypertensive vascular disease without cardiac enlargement on roentgen examination, 7 had hypertensive vascular disease and cardiac enlargement on roentgen examination, and 7 had classical and relatively stable angina pectoris.

It was demonstrated that tocopherol therapy produced no appreciable benefits either subjectively or objectively. Neither in symptomatology nor in objective findings was there significant improvement. Specifically there was no lowering of the blood pressure, no decrease in the size of the heart demonstrable roentgenologically, nor improvement in the electrocardiogram. The changes recorded indicating improvement in some and progression in others were only such as might be expected in the natural evolution of their cardiovascular disease. No toxicity from the drug was noted in any patient. There was no correlation between the level of blood plasma tocopherol and the clinical course of the disease. It was noted that in patients with congestive heart failure, the tocopherol blood levels were normal and not reduced. It was, however, shown that the blood level of tocopherol can be significantly raised by the oral administration of the drug.

VISCOSITY STUDIES OF ERYTHROCYTES FROM PERSONS WITH SICKLE CELL DISEASE. By William M. McCord, William H. Kelley, Paul K. Switzer and F. Bartow Culp. *Proc. Soc. Exper. Biol. & Med.* 69:19-22, 1948.

These authors set out to investigate the possibilities of the viscosimetric method as an objective means of measuring the sickling tendency of the red cells of individuals or groups of persons under varying conditions. Such a method is described for the study of this tendency of red cells from subjects with sickle cell disease. This method does not differentiate between sickle cell anemia and sickle cell trait. Data are compared with observations of other investigators.

PEDIATRIC PROCTOLOGY. By Claude G. Mentzer, M.D. *South. M. J.* 41:798-803 (Sept.) 1948.

The author discusses the role of abnormal elimination in pediatric proctology, its management, and the treatment of anorectal disorders associated with it. His observations are based on an analysis of 75 of 127 consecutive cases in his practice. He concludes that the need for collaboration between pediatrician and proctologist cannot be stressed too much and adds that pediatricians, and general practitioners who take care of children, have the opportunity and duty to practice preventive medicine. With the help of the mothers, they can establish proper habits of elimination in the preschool child so that desirable physiologic practices may be firmly fixed before school days begin, and thereby greatly lessen the incidence of anal and rectal disorders.

TOXEMIA SUPERIMPOSED UPON PREPREGNANT HYPERTENSION TREATED BY SPLANCHNICECTOMY. By Max M. Peet, M.D., Emil M. Isberg, M.D., and Robert C. Bassett, M.D. *Surg., Gynec. & Obst.* 86:673-679 (June) 1948.

Bilateral supradiaphragmatic splanchnicectomy with lower dorsal sympathetic ganglionectomy is a new therapeutic approach to the problem of toxemia superimposed on prepregnant hypertension. Five cases are reported in which this surgical treatment was aimed directly at the underlying hypertensive disease in the belief that the complicating toxemia is a consequence of the pre-existing hypertensive state. In 2 cases the results were excellent; the toxemia disappeared, blood pressure levels became normal, living infants were obtained, and normal blood pressures had persisted for four and two years respectively following delivery. There was no influence on the toxemia in the remaining 3 cases, but in 1, the blood pressure levels following delivery were significantly decreased as compared to the prepregnant levels.

The authors recommend that splanchnicectomy be considered in cases of toxemic pregnancy superimposed on pre-existing hypertension before decision to interrupt the pregnancy is reached. In their opinion the surgical treatment of hypertension not only affords an opportunity for relief from the toxemia and a good chance to obtain a living infant, but it also presents the significant possibility of gaining a lasting relief from the underlying hypertensive state.

DIABETES MELLITUS: PRACTICAL MANAGEMENT OF AMBULATORY CASES. By Carlos P. Lamar, M.D. Medical Times (Sept.) 1949.

In this article Dr. Lamar presents a general outline of the procedures for the management of ambulatory diabetic patients without complications, carried out in his private practice and for his clinic patients. The care of these patients should be directed by the general practitioner, he avers, and the management may be carried out in simple ways, usually without need of expensive hospitalization. Therapeutic aims include essentially the restoration and maintenance of normal strength and weight, normal well-being and clear or aglycosuric urines with normal blood sugar levels.

The author's system of diet prescriptions, simple and easily understood by most patients, features individual caloric requirements for each patient, regulated according to his body weight responses to an average or standard observation diet. This diet is arranged with average portions of common foods, adequate to the patient's excess or lack of body weight.

A simple method for estimation of insulin dosage is presented. The importance of continuous education and careful supervision is stressed, and normal physical activities and a healthy mental attitude are regarded as not only a consequence but an indispensable part of good diabetic management.

MULTIPLE CYSTIC TUBERCULOSIS OF THE BONES. By McLemore Birdsong, M.D., and Camillus S. L'Engle, Jr., M.D. Pediatrics 1:767-770 (June) 1948.

A case is reported in which cystic tuberculous lesions were present in the flat and long bones as well as in the bones of the hands and feet. This combination, apparently occurring rarely, was observed in a white boy aged 13 months and is the fourteenth case of multiple cystic tuberculosis reported in pediatric literature. Other authors reported similar cases, but without recovery of the tubercle bacillus from the actual lesions. It is generally agreed that these lesions occur secondarily to tuberculosis elsewhere and the infection is spread by the blood stream.

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The Rice Diet

The "Rice Diet" and its effect upon arterial hypertension have been the subject of much discussion during the past few years. A few strong advocates for and against this method of treating hypertension have been locked in mortal combat, while a majority of clinicians have sat on the sidelines watching the titanic struggle with a bit of healthful doubt and a wee bit more—even a generous dash—of humor and good nature.

The first reported results of treatment with the "Rice Diet" appeared to be strongly favorable, yet the over-all theory seemed weak. Reduction of the obese person's weight was accepted by all as being sound, but the administration of a low protein, low mineral diet to all for an extended period of time was not accepted by an inquiring few. Some of the doubting Thomases questioned the control studies. They objected to the strong psychosomatic approach that was made while the diet was being administered, with results reported as if due to the diet alone.

In an article published in the *Annals of Internal Medicine* for April 1949, Drs. Henry A. Schroeder, Palmer H. Fitcher and Melvin L. Goldman reported the results of their observations upon this method of treating hypertension. Their summary and conclusion were:

On the basis of this study, a diet of unsalted rice, fruit juices and vitamins is of questionable value in the treatment of most patients with arterial hypertension. When the disease process was advanced, neither salt restriction nor the rice diet appeared to be efficacious. . . . The regime advocated by Kempner. . . has strong psychotherapeutic influences. . . and control periods in hospital. . . have not been shown. . . .

It would seem that those physicians who followed the age-old advice of Alexander Pope can now take a deep breath of satisfaction:

Be not the first by whom the new are tried. . .

"In One Door and Out the Other"

Lord Horder, physician to King George VI, who at 79 heads a dozen important medical and civic societies in Great Britain, pictured demoralized doctors and curtailed hospital service under his country's nationalized medicine program when he attended the recent Seventh International Congress on Rheumatic Diseases in New York. He remarked that the whole philosophy of the general practitioner has changed, for the doctor who was accustomed to ask "What's ailing you?" now is forced to ask "What do you want?"

It may be wigs, toupees, girdles, glasses, or wheel chairs that the patient wants. A case in point was related in a letter to the editor, published in the *London Daily Express*, and given publicity in this country in a broadcast by Fulton Lewis, Jr., on September 20. A doctor in the British free medical program, on request, gave a certificate for new canvas for a specially strengthened invalid chair to a patient who had used it for shopping for years. At the local Health Ministry offices it was decided that the chair was out-of-date and that she must have a new one. Back she was sent to the doctor, who gave her the required note saying she needed an invalid's chair and another note

to the hospital, which then issued a certificate stating that she qualified for a chair.

Weeks later, the medical officer summoned her to insist that an electric chair would be more suitable, but she was adamant, preferring one of her husband's three cars when she wished a motorized vehicle. Yielding, he replied, "But you must have a garage with the chair we are giving you." Despite her protest that she had ample garage room, eventually a surveyor and two men arrived to select the site for the garage. Now she has a new chair and its garage when all she wanted was permission to buy a piece of canvas.

Lord Horder said that he knew doctors who had had to take on as many as 4,000 patients in order to make a living under the plan and added that "about all they can do is run them in one door and out the other." The recent announcement of greatly reduced hospital expenditures, with wards and laboratories already being closed, had scarcely alleviated the "smoldering discontent" of the British medical profession toward the Ministry of Health, he observed, adding that "there's nothing we can do about it as the law prohibits raising money in the old way."

At this writing, Britons have just had a poignant reminder that free medicine after all is not free. Not only does the British taxpayer, and indirectly the American taxpayer, pay and pay, but now it is decreed that the individual patient must pay a shilling, approximately 14 cents, for a prescription. This entering wedge is not only an admission of failure but it is believed in reliable quarters that it heralds a specific charge on nearly all services, or a weekly health deduction from pay envelopes up sharply enough for the patients to know that the so-called free service is not free.

"Those Selfish Doctors"

The editorial eye fell upon a lay editorial recently which is worthy of remark and furnishes the title for this comment. It observes that the American medical profession, "excoriated by Mr. Truman and the federal security administrator, the selfless Oscar Ewing, as a bunch of merchants of death," appears to have little chance of enjoying its ill gotten gains. It seems, instead, that these American physicians who are accused of leaving their fellow citizens in neglect are exhausted by their labors and precede them in death.

The theme song of the Washington bureaucrats has been the claim that tens of thousands of per-

sons die needlessly in this country every year because of lack of medical care. The omniscient Mr. Ewing puts the figure at 325,000. It is, however, left to the American Medical Association to bring out that such a figure must include 40,000 deaths from accidents and 115,000 from cancer and heart disease, whose victims "could not be saved by a whole convention of doctors."

This association found that the average age of white males in this country at the time of death is 67.5 years, and for physicians 67.3 years. Physicians, it appears, have no better chance of escaping the hazards of accident and disease than anyone else. In fact, heart disease accounted for 42.2 per cent of deaths among physicians, as against 38.9 per cent of deaths among white males of comparable ages. Cancer, ranking second as a cause of death among the population at large, takes third place among physicians, who probably recognize symptoms earlier and begin treatment promptly. Nevertheless, they die of it the same as other people do, and in about the same proportion.

Citing these facts, the lay editorial concluded: "It is to be supposed that the Truman prescription for political medicine to save 'needless deaths' would also save the lives of physicians who cannot give each other longer lives than they give their patients. If that shouldn't work, Truman might try passing a law saying that all physicians shall live to be 95 so as not to spoil his propaganda."¹

1. Chicago Sunday Tribune, May 1, 1949.

Postgraduate Assembly in Endocrinology Including Diabetes

A practical course of postgraduate studies in Endocrinology and Diabetology will be presented at the Roney-Plaza Hotel in Miami Beach, April 3-8, 1950. The lectures, clinics and demonstrations will be of high interest and value to the specialist and the general practitioner alike. Ample time will be given to questions and answers at the close of each session, and registrants will be encouraged to contact members of the faculty for individual discussions.

Prominent researchers and clinicians in the field of endocrinology and metabolic disorders will comprise the faculty. They have been gathered from the various scientific centers throughout the United States and Canada.

A fee of \$75 will be charged for the entire course, and the attendance will be limited to 100.

Registrations will be in the order of checks received and will close on March 3, 1950. Should there be an insufficient number of applicants to fill the course, the registration fee will be refunded immediately in its full amount. This course has been approved by the Veterans Administration for its physicians.

Applications, on personal letterhead, together with check payable to the Association for the Study of Internal Secretions, should be forwarded to Henry H. Turner, M.D., Secretary-Treasurer, 1200 N. Walker St., Oklahoma City 3, Okla., before March 3. Further information and the program will be furnished upon request.

The special convention rates offered for this assembly by the luxurious Roney-Plaza Hotel afford an unusual opportunity for physicians to participate in a highly instructive program presenting the latest advances in endocrinology and metabolism and at the same time enjoy with their families a pleasant vacation. Hotel reservations should be made directly with the Roney-Plaza Hotel, Miami Beach, and the hotel should be advised that the applicant will attend this Post-graduate Assembly.

Dr. Carlos P. Lamar of Miami is chairman of the local arrangements committee and of the section on diabetes of the assembly. It is expected that many Latin American physicians will attend this important event.

Seminar on Cancer Birmingham, Feb. 21-23

Florida physicians are invited to attend a three day Seminar on Cancer at the Medical College of Alabama in Birmingham on February 21, 22 and 23. It is sponsored jointly by the Medical Association of Alabama, the Jefferson County Medical Society, the Extension Division of the University of Alabama and the Alabama Division of the American Cancer Society.

The program has been arranged to give physicians the up-to-the-minute information they have indicated they desire most on new and advanced methods of detection, diagnosis and treatment. In the subjects chosen for presentation, the dissimilar problems that confront the specialist and the general practitioner have been given due consideration.

At least ten specialists widely recognized for their work in their various fields will lecture. They include Drs. Louis H. Clerf, Harry Bacon and/or Lloyd F. Sherman, Philadelphia; Frank

Adair, Oliver S. Moore and Alexander Brunschwig, New York; A. N. Arneson, St. Louis; William F. Reinhoff, Baltimore; Sidney Farber, Boston; and Ralph W. Caulk, Washington. At a dinner at the Tutwiler Hotel climaxing the first day's sessions, Dr. Charles S. Cameron, Jr., New York, Medical and Scientific Director of the American Cancer Society, will be the speaker.

It is expected that out-of-state representation will be large for an invitation has been extended to members of all state and county medical societies throughout the Southeast. There is no registration fee. Reservations for the Seminar should be made through Dr. Karl F. Kesmodel, Medical Arts Building, Birmingham. Hotel reservations should, however, be made direct with the headquarters hotel, The Tutwiler, or with nearby Hotel Molton or Hotel Redmont.

Graduate Medical Education Schedule

The Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health announces its program for the year 1950. As has been the policy in the past, the Department is endeavoring to bring the best possible graduate medical education to the physicians of Florida. A variety of courses is planned in order that both the specialists and the general practitioners will find them informative and stimulating.

The lecturers chosen are again authorities in their respective fields. They will present the latest developments and advances in their specialties.

Last month the Midwinter Seminar in Ophthalmology and Otolaryngology was as usual held in Miami Beach, from the sixteenth through the twenty-first. The dates for the Special Graduate Short Course held in Jacksonville were January 23 to 28.

A Diabetes Seminar is scheduled for Tampa in March, with details to be announced shortly. The Special Course on Cardiovascular Diseases will this year be held in May instead of June, the dates being May 15-20. The Tuberculosis Seminar follows on May 24-26 in Orlando.

The Eighteenth Annual Graduate Short Course is scheduled for the week of June 26, concluding on July 1. It will be held at the usual place, the George Washington Hotel in Jacksonville.

Further details will be published later in The Journal. Additional information may be obtained from the Department of Medicine, 2033 Riverside Ave., Jacksonville, or from the members of the Committee on Medical Postgraduate Course of the Florida Medical Association.

Report of Delegates to A. M. A. Convention Washington, D. C., Dec. 6-9, 1949

The House of Delegates of the Third Clinical Session of the American Medical Association was called to order at 10:00 a.m., Dec. 6, 1949 in the Presidential Room of the Statler Hotel in Washington, D. C. by the Speaker of the House, Dr. F. F. Borzell. One hundred eighty-seven of the possible one hundred ninety members of the House were present. The Florida delegates were present and active.

Those nominated for the General Practitioner's Award were Drs. Andy Hall of Mt. Vernon, Illinois, Lyle (Bunny) Hare, Spearfish, South Dakota and Thomas Edwin Rhine, Thornton, Arkansas. Dr. Andy Hall was elected by a vote of the House and the award was made at a cocktail party given by the Board of Trustees on the evening of Dec. 6, 1949. Dr. Hall was born on a farm in southern Illinois nearly 85 years ago and his first years of schooling were spent in a one room log schoolhouse. He attended Illinois Normal and Business College at Dixon and for a while taught school. After graduating from Northwestern University Medical School in 1890 he located in Mt. Vernon where he has practiced medicine for nearly sixty years. He still makes house calls and goes to his office daily. He has done postgraduate work at various clinics in the Midwest. He was for four years director of the Illinois State Department of Health. He has been vigorously active in his county medical society serving as secretary for 15 years and later as president. He was president of the Southern Illinois Medical Society and councilor of the state medical society for 19 years. He served his county in the Spanish-American War and Philippine Insurrection and World War I. During World War II he was chairman of the Medical Board of Appeals under the Selective Service Act. He is active in church work, the Knights Templar and veterans' organizations. He still travels with high school basketball teams, (state champions this year) to their principal games. He is skillful, generous and devoted to his patients. At the age of 32 he was elected

mayor and for 8 years was head of the township high school board. The Mt. Vernon Chamber of Commerce voted him its annual civic award for outstanding and distinguished community service.

In the remarks of the Speaker of the House, he directed the attention of the members to the fact that the Department of Justice was now examining all the files and records of the American Medical Association and of some 22 county medical societies in an effort to obtain some information that might incriminate the medical profession, information which they certainly do not possess or they would not be in search of it. He feels that the county and state societies should be drawn closer together in an effort to further advancement of medicine and medical care. Members of state and county societies are urged to attend the sessions of the House of Delegates.

President, Dr. E. E. Irons, in a very forceful address reminded us that we must continue our fight against the socialization of medicine with dignity but with force, that we have considerable evidence of progress but warned against relaxation. We have no alternative but to get into the fight politically for it is our duty to defend the American way of life, he advised. We were told that the government is sending a group, at the tax payers' expense, to Europe to get more ammunition with which to fight. It is anticipated, Dr. Irons believes, that the ammunition will not be too greatly to their liking, for a group of Congressmen who were in favor of state medicine made a trip to Europe and returned with changed minds after seeing what has happened in England. He also pointed out that we are slowly being led down the road to the welfare state and that it is our responsibility to stop it, a responsibility which we cannot delegate to anyone else.

Dr. Elmer Henderson, president-elect and chairman of the Coordinating Committee of the National Educational Campaign gave a fitting address along with his report of the activities of the committee. He called 1950 "Medicine's Armageddon" and states, in part, "American Medicine, during 1949, became a well organized powerful fighting force for freedom. It met its enemies in spectacular contest before the people and its enemy gave ground. At the 1949 Session of Congress the fight for compulsory health insurance was abandoned, even though the White House itself had become a sounding board for the Socializers. Let's reach our objectives in 1950—let's face our battle of Armageddon, proud to carry the

banner for American Medicine and our American way of Life."

One of the more important steps taken by the House of Delegates was to amend the By-Laws of the Association so that for the first time in the history of the Association members will be required to pay annual dues. The dues as recommended by the Board of Trustees and approved by the House in 1950 are \$25.00 a year. Each member on payment of his dues will receive a card and a certificate of membership will be entitled to attend the scientific sessions of the American Medical Association which previously have been limited to Fellows and invited guests. An official notice of this action of the House will be sent to each constituent Association which will arrange for the collection of the dues according to the local custom in the collection of dues. It is not the wish of the American Medical Association House of Delegates to collect dues from physicians who are retired because of old age or physical disability or who would suffer financial hardship because of such payment. It is the wish of the House, to have all physicians in active practice and in medical teaching as paid members of the American Medical Association. An active member who becomes delinquent in payment of his dues will forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after notice of the delinquency has been mailed by the secretary of the A. M. A. to his last known address.

It is the belief of the House of Delegates that the American Medical Association like other great national organizations must be able to depend on dues for the support of the growing program of service to the profession and to the public. The responsibilities of the Association are increasing constantly and the revenue from its publications cannot now meet the cost of this expanding program. Much of the collected dues will be used to promote voluntary health insurance plans. Included in the attempts toward furthering the adoption of voluntary insurance will be endeavors to encourage plans for individual subscribers, protection coverage for those over 65 years of age and inauguration of special coverage for those faced with "catastrophic" illnesses. Some of the money collected from dues will be used to fight the administration's compulsory health program.

The full effect of the new provisions will have to be studied and developed during the next year.

However, the following interpretation of the amended By-Laws is offered for your guidance at this time: (a) Active membership in the American Medical Association will continue to be limited to those members of constituent associations who, first, hold the degree of Doctor of Medicine or Bachelor of Medicine and, second, are entitled to exercise the right of active membership in their constituent associations as provided in Article 5 of the Constitution of the American Medical Association. (b) A member of the American Medical Association shall lose his membership in the Association when the secretary of the American Medical Association is officially informed that a member is not in good standing in his component society or is delinquent in the payment of the American Medical Association dues established by the above change in the By-Laws. (c) Forfeiture of membership in the American Medical Association due to failure to pay dues will have no effect on the component or constituent medical societies unless the component or constituent societies so amend their respective Constitutions and By-Laws. It is, therefore, possible that a physician may be a member of his component or constituent society and at the same time not be a member of the American Medical Association. (d) The amended By-Laws provide for the collection of the American Medical Association dues by the constituent association for transmittal to the secretary of the American Medical Association. The detail method to be adopted by each constituent association will vary in each state. In general, the method utilized in each state for the collection of its own component or constituent association dues should be followed.

No changes have been made in the Constitution or By-Laws of the American Medical Association with respect to Fellowship. Eligibility for Fellowship and annual Fellowship dues of \$12.00 remain the same. Under the present By-Laws a Fellow will pay for the year 1950 a total membership and Fellowship dues of \$37.00. The following members may be exempted from the payment of \$25.00 American Medical Association membership dues: retired members, members who are physically disabled, internes and those members for whom the payment of such dues would constitute a financial hardship.

No member shall be exempted from the payment of the American Medical Association dues who is not exempted from his component or constituent society dues.

There were, of course, numerous officer and

council and committee reports; also numerous resolutions introduced into the House, the majority of which were of matters already effective in the medical association or of such matters that would not be appropriate at this time. Many others were passed and all of these reports can be read in detail in the December 17 and 24, 1949 issues of the Journal of the American Medical Association.

It might be interesting to you to note in the report of the Council on Medical Service that in December 1948 the House of Delegates authorized reorganization of the Council which is in the process of reorganization now. They are appointing in this Council correlating committees who will report to the Council. The first is a Correlating Committee on the Extension of Hospitals and Other Facilities; second, the Medical Care of the Industrial Worker; third, the Correlating Committee on Indigent Care; fourth, the Correlating Committee on the Care of Veterans (your delegate, Dr. Louis M. Orr of Orlando, is a member of this committee); fifth, the Correlating Committee on the Prepayment of Hospital and Medical Service; sixth, the Correlating Committee on Relations with Lay-Sponsored Health Plans and seventh, the Correlating Committee on Maternal and Child Care. It is felt that the reorganization and the broadening of the activities of this Council will be of great help to the Association and its members.

Report on the Committee on Displaced Physicians. This committee was appointed by the Board of Trustees in accordance with a resolution passed by the House of Delegates in the 1949 annual session and has made, in part, the following report: "Of the more than 2600 displaced physicians in the occupied zones of Europe a number have already immigrated to this country and many more, it is anticipated, will come although there are probably almost two thousand remaining in Europe at the present time. Among these physicians there are some who escaped into western Germany without any personal documents as to graduation from medical school or evidence of their status as practitioners in their own country. For a large proportion of these individuals it is impossible to obtain certificates of graduation from medical schools which are located in areas under Russian control. The International Refugee Organization has checked all credentials and other evidences of professional status of every one of

these physicians and has certified all those found worthy of such certifications for medical work among the displaced populations of which they form a part. Medical and public health activity for the past four years has been carried on among these people under the direction of the International Refugee Organization and the health standards and statistics will bear comparison with any civilized nation. Among the displaced physicians there is about the proportion of specialties, teachers and other leaders of the profession as would be expected in the population of any civilized country. These physicians, like the other displaced persons, are homeless, penniless and cannot return to the country from which they came because their return to areas under Communist control, to which they are known to be opposed, would mean imprisonment or death.

With the above facts in mind the Committee on Displaced Physicians makes the following recommendations: first, that the American Medical Association suggest to the state medical examining boards and to the Federation of State Medical Boards of the United States that they give special study to the present unique situation with respect to displaced physicians with the idea of framing special regulations to meet the problem; second, that the plan of accepting International Refugee Organization certification in lieu of other evidence of graduation and other professional status when such evidence cannot be obtained, be suggested to the state medical examining boards; third, that efforts be made by state medical examining boards to arrange for the appointment of displaced physicians in state hospitals as has been done in Iowa, and in such other hospitals as may be possible, thus enabling such physicians to become better acquainted with American medical methods and practices; fourth, that state medical boards be urged to consider the framing of special regulations designed to make it possible for specially qualified displaced physicians to be licensed for limited practice in a community and hospitals where their services are needed; fifth, that the American Medical Association recommend to the appropriate departments of the Federal Government that steps be taken to allow the utilization of the services of displaced physicians certified by the International Refugee Organization in Federal Services such as the Indian and Alaskan Services under the Department of Interior where it is understood that a great need for physicians exists and sixth, that a copy of this report be sent to the secretary of

each state medical examining board and to the secretary of the Federation of State Medical Examining Boards of the United States."

This report will, of course, have to be studied in detail by the Florida State Board of Medical Examiners since at the June 1949 meeting a resolution was adopted to accept no more graduates of foreign medical schools or Grade B medical schools for examination by the Florida State Board of Medical Examiners.

During the closing session of the House of Delegates Mr. George Craig, National Commander of the American Legion, was introduced and spoke briefly, in part, as follows: "We of the American Legion realize that you are here to take action not only on matters which pertain to your profession but also to those which pertain to the general welfare. I think and know you realize that you and the American Legion are on the same team. We believe in the same principles of government that you believe in, we want to join with you and want you to join with us and do something about it. You well know the stand of the American Legion on Socialized Medicine, compulsory health insurance and all those other matters that puts the government into the life of the individual, removes the government from the control of the people.

"I might say to Mr. Ewing and the other proponents of these programs that I am reminded of an old Confederate general who lived many years after the War between the States, or the Civil War, depending upon which side of the river you came from. He had a grandson of whom he was very proud, a sterling man of character. The young man had obtained through appointment the position of cadet at West Point. He was fearful that if the old grandpa who was still living in the days of Appomattox heard about it, he would refuse to let him go north to school. So, the young man concealed from his grandfather the plans he had until the night before his departure and he went to the old man's room late that night and he said, 'Grandfather, tomorrow I am going to college. I am going to the United States Military Academy at West Point.' The old man's eyes twinkled and he didn't say anything. He said further, 'Grandfather, that is north of here.' His grandfather said, 'That is all right, son, you go up there to West Point, you study hard, get acquainted with as many people as you can, learn all about those people that you can, then you come back here because this shootin' ain't over yet.'

"So I think that you and I, the American Medical Association and the American Legion

may advise our adversaries that we have just begun to fight."

Other activities of this House of Delegates consisted of: deliberations directed at the Board of Trustees to make appropriate studies for the creation of a Junior American Medical Association and to report at the next meeting of the House of Delegates; authorization of a committee of 5 members of the House of Delegates to be appointed by the Speaker of the House to study the status of veterans with non-service-connected illnesses and report back at the next meeting; urging the development of systems to handle emergency calls; making a report of the progress of the American Medical Association National Education Committee; stating that Public Health officers should receive salaries commensurate with their responsibilities in comparison with others who have similar responsibilities; authorizing the appointment of a committee of lay persons to help in the National Education Campaign; calling attention to the neglect by the Federal Government of the Army Medical Library and urging the Army, the President of the United States and the Congress to make provisions for adequate quarters for this invaluable service; and to encourage the establishment of grievance committees, or comparable programs, by constituent associations to permit the hearing of complaints from the public.

More than 8,400 attended this Clinical Session of the American Medical Association. Out of this number more than 3,000 were Fellows of the Association. A succession of Clinical presentations were offered in a wide variety of the fields of medical endeavor. Motion pictures, television in color and black and white, as well as technical and scientific exhibits provided additional evidence of the success of this session. Radio, likewise, played a predominant role and many interviews were arranged for broadcast. Some of the broadcasts were transcribed for reproduction over the "Voice of America."

The next session of the American Medical Association will be in San Francisco, June 26-30, 1950. The Board of Trustees announced the retiring of Dr. Morris Fishbein by mutual agreement as Editor of the Journal of the American Medical Association, effective Dec. 1, 1949, and the appointment to this editorship of Dr. Austin E. Smith.

Respectfully submitted

Homer L. Pearson, Jr., M.D.

Louis M. Orr, II, M.D.

YOUR BLUE SHIELD

Facts about Blue Cross-Blue Shield Series "7" Contract Availability

At present the new Series "7" Blue Cross and Blue Shield contracts are being offered to members of all present Blue Cross-Blue Shield groups and to all new members. All groups were notified of the new contracts by mail and were sent descriptive literature. Blue Cross-Blue Shield representatives are now in the process of calling on all groups for the purpose of personally explaining the Series "7" Contracts to the group members and assisting in the conversion to the new coverage. As rapidly as possible direct payment members will be notified of the availability of the Series "7" Contract and at that time holders of Blue Cross contracts only will be given an opportunity to enroll in Blue Shield.

Rates

Group rates for the combined Blue Cross-Blue Shield Series "7" Contract are as follows: \$2.40 a month for a single man or woman (about 8c a day); \$5.80 a month for a family (man, wife and all unmarried children under 19 years of age), which averages about 19c a day for a family, or 5c a day for each member of the average family.

New Doctor's Service Report

By now all participating physicians have received a supply of the new Blue Shield Doctor's Service Report which is to be completed for all Blue Shield cases. To conform with the Series "7" Contract, these forms include a section for reporting medical services rendered Blue Shield subscribers while in the hospital. The new Blue Shield In-Hospital Medical benefit provides for payment up to \$5.00 for each daily visit made by a participating physician in charge of the case, commencing on the fourth day of the patient's hospitalization for non-surgical, non-obstetrical cases, up to twenty-eight visits in any one contract year.

Physicians are urged to complete a Doctor's Service Report for each Blue Shield case immediately after the services have been rendered and send it to the Blue Shield office in Jacksonville in order that payments may be kept current. Additional supplies of Doctor's Service Reports will be furnished upon request to the Blue Shield Plan at Box 1798, Jacksonville, or to any of the following area offices: Gainesville: Mr. Gilbert Cook, P. O. Box 420; Lakeland: Mr. Norman

Cason, 909 S. Tennessee Avenue; Miami: Mr. John C. Lee, 411 Chamber of Commerce Building; Orlando: Mr. John R. Brothers, P. O. Box 1305; Pensacola: Mr. Paul M. Miller, 117 South Baylon Street; St. Petersburg: Mr. Arthur Tatum, 2220 19th Avenue South; Sarasota: Mr. James R. Ogburn, P. O. Box 1628; Tallahassee: Mr. F. T. Stallworth, Tallahassee Memorial Hospital; Tampa: Mr. Leonard Brown, Room 21, Western Union Building and West Palm Beach: Mr. S. Bruce Lynes, P. O. Box 1686.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Herman K. Moore of Key West announce the birth of a daughter, Linda Jean, on Aug. 3, 1949.

Dr. and Mrs. Wallace H. Mitchell of Key West announce the birth of a daughter, Edna Allison, on Nov. 2, 1949.

Deaths — Members

Farber, Chas. K., St. Petersburg..... Dec. 6, 1949
McGinnis, Robert H., JacksonvilleDec. 27, 1949
O'Quinn, Leon H., Hialeah..... Dec. 13, 1949

STATE NEWS ITEMS

The Georgia Society of Ophthalmology and Otolaryngology will hold its annual meeting at the General Oglethorpe Hotel in Savannah, March 3-4, 1950.

Eminent lecturers on the program and their subjects are: Dr. Bayard T. Horton, Rochester, Minnesota, "Treatment of the Dizzy Patient" and "Headaches — Common Varieties and Their Treatment"; Dr. John M. Converse, New York City, "Treatment of Acute Maxillofacial Trauma" and "Rhinoplasty"; Dr. Mercer G. Lynch, New Orleans, La., "Carcinoma of the Larynx and Methods of Approach including Lynch Suspension" and "Radical External Sinus Operations"; Dr. Meyer Wiener, Coronado, Calif., "Medical Ophthalmology" and "Surgical Ophthalmology"; Dr. Milton L. Berliner, New York City, "Slit Lamp Microscopy"; Dr. Wendell L. Hughes, Hempstead, N. Y., "Lid Reconstruction" and "Personal Procedures in Ophthalmology."

WANTED: E.E.N.T. specialist in one of Florida's most beautiful towns retiring, wishes successor. No cash. Write 69-30, P. O. Box 1018, Jacksonville.

GENERAL PRACTITIONER desires location in Florida. Competent, ethical, early fifties; city of 5,000 up, hospital facilities, east coast preferred; office lease, group, home residence combination or home. Write 69-31, P. O. Box 1018, Jacksonville.

Dr. DeWitt C. Daughtry has opened offices at 2300 Biscayne Boulevard, Miami, with practice limited to thoracic surgery and broncho-esophagology. Dr. Daughtry was formerly Chief of Thoracic Surgery at McGuire General Hospital in Richmond, Virginia.

Charles S. Haupt has been appointed Associate Director of the Bureau of Professional Relations of the College of Pharmacy of the University of Florida. He replaces L. W. Harrell, who resigned in September to enter the retail drug business in Palatka, Florida.

Mr. Haupt is a graduate of the College of Pharmacy of Duquesne University. He is a registered pharmacist in both Florida and Pennsylvania. Mr. Haupt has a long record of drug store experience, including eleven years as an owner. In World War II he served for six years in the U. S. Navy Hospital Corps, during which time he was awarded a certificate in Hospital Administration by the U. S. Naval Officers School.

Since 1947 Mr. Haupt has been employed by the Veterans Administration as Rotating Pharmacist, Assistant Chief, and Chief of the Pharmacy Division in Atlanta, Georgia.

Dr. Chester H. Murphy, Bartow, explained the advances that the science of medicine has made in the past 100 years at a recent meeting of the local Rotary Club.

In order to prove his point that medicine has progressed more in the last 100 years than in all times previous to that, Dr. Murphy delved rather extensively into the history of medicine and the medical profession.

Florida physicians who attended the Obstetric Seminar at the University of Georgia School of Medicine, in Augusta, December 12-16 are: A. F. Thomas, Cocoa; Lawton F. Douglass, Eustis; Lester L. Whiddon, Ft. Pierce; Walter E. Murphree, Gainesville; Elmer E. Leitner, E. Frank McCall, Irving J. Strumpf, Max Suter and Walter Wilkins, Jacksonville; Bruce D. Carroll, William M. Howdon, Homer L. Pearson, Jr., John T. Smedley and Richard F. Stover, Miami; Maurice J. Rose, Miami Beach; Leland H. Dame, Orlando; Joseph W. Douglas, Pensacola; William G. Meriwether, Plant City; T. Paul Haney and Edward V. Pollard, St. Petersburg; Frank L. Quillman, Sanford and Oren A. Ellingson, Tampa.

Dr. Webster Merritt of Jacksonville was the guest speaker at a recent meeting of the St. Augustine Historical Society and Institute of Science. Dr. Merritt is the author of a recently published history of medicine, "A Century of Medicine in Jacksonville and Duval County."

Dr. Howard G. Holland, Leesburg, and Dr. Carl D. Hoffman, Orlando, have returned to their practices following a brief journey to England by air to make a first hand study of state medicine as now being practiced in that country.

Dr. W. Wardlaw Jones of Dade City presented to the local Kiwanis Club a review of his recent trip to Havana. Dr. Jones described various tours of the island including the Havana medical school where 3,000 students are in attendance. Only residents of Cuba are allowed to be students. He described the schools and hospitals as being modern and progressive.

Dr. Fred S. Gachet of Lakeland spoke to the Mothers' Club of the Happy Hours School of Lake Wales recently. Dr. Gachet's talk dealt primarily with problems of every day care of children. He outlined the normal developments of children from birth to age seven, including normal amounts of sleep and food. In response to questions, he discussed, among other things, speech difficulties and their causes and feeding problems.

Dr. Frank G. Slaughter of Jacksonville was a guest speaker on December 13 at a luncheon meeting of the Woman's Club in Starke.

Dr. Robert G. Neill of Orlando, a graduate of the Duke University School of Medicine, was the guest speaker at a dinner to celebrate Duke University Day at the St. Petersburg Yacht Club. His topic was "The Role of the Brain Surgeon in the Relief of Pain."

Dr. Millard P. Quillian of Bradenton presented to the local Rotary Club a summary of the qualifications necessary for entrance to the average medical school.

Dr. Richard C. Cumming, Ocala, was the guest speaker at a recent Fellowship meeting of the local Parent Teachers Association.

ANNUAL CONVENTION
April 23-26, 1950
Hollywood Beach Hotel

The Southeastern Surgical Congress Post-graduate Assembly has announced its Eighteenth Annual Meeting for March 6-9, 1950, Washington, D. C. Included among the outstanding guest speakers on the program will be Dr. Louis M. Orr, II, Orlando, who will speak on cancer of the urinary bladder and Dr. Joseph S. Stewart, Miami, who will present a paper dealing with gastric resections and vagotomies.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bell, Bernard T., St. Petersburg
Benton, Curtis D., Jr., Ft. Lauderdale
Bloch, Valentine, Miami
Daughtry, DeWitt C., Miami
Exum, William A., Ft. Lauderdale
Futterman, Saul G., Miami
Griffin, George W., Orlando
Hyde, Robert T., Atlantic Beach
Osterhout, Gail M., Inverness
Simpson, Morrell, St. Petersburg
Spicola, Louis A., Tampa
Steinberg, Benjamin L., Lake City
Wells, Samuel M., Jacksonville

COMPONENT SOCIETY NOTES

Alachua

Officers of the Alachua County Medical Society for 1950 are Dr. Stuart D. Scott, president, and Dr. Henry H. Graham, secretary-treasurer. Elections were held at the regular December meeting.

Bay

The Bay County Medical Society, at its annual election of officers in December, elected Dr. Daniel M. Adams, Jr., as president for 1950. Other officers to serve with Dr. Adams are Dr. Charles H. Daffin, vice president, and Dr. Jack Corbitt, secretary-treasurer.

Brevard

Dr. Arthur C. Tedford of Melbourne has been chosen as president for 1950 of the Brevard County Medical Society. Dr. Allen E. Kuester of Cocoa was elected vice president and Dr. Theodore J. Kaminski of Melbourne was re-elected as secretary-treasurer.

Columbia

At the regular December meeting of the Columbia Medical Society, officers were elected for the year 1950. Dr. Robert B. Harkness of Lake City was re-elected president, and Dr. Sybill Corbett of Jasper was re-elected vice president. Dr. Thomas H. Bates of Lake City was re-elected secretary-treasurer.

Dade

Dr. Donald W. Smith of Miami will serve as president of the Dade County Medical Association for the coming year, succeeding Dr. John D. Milton, president for 1949. Dr. Smith has served the past year as president-elect in accordance with the Association's policy. Dr. Jack Q. Cleveland of Coral Gables has been named president-elect for 1950. Other officers who will serve during the coming year are Dr. Edward W. Cullipher, Miami, vice president, Dr. Reuben B. Chrisman, Jr., Miami, secretary and Dr. Ralph S. Sappenfield, Miami, treasurer.

Among the first activities performed by Dr. Smith, as the new president, was to hold a meeting of the Association's public education committee and its public relations chairman with representatives of the local newspapers on December 8.

DeSoto-Hardee-Highlands-Charlotte-Glades

At the regular December meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, the 1950 officers were elected. They are Dr. Roland W. Banks of Wauchula, president; Dr. Wesley S. Pyatt of Bowling Green, vice president; and Dr. James G. Smith, Jr., of Wauchula, secretary-treasurer.

Duval

Dr. James L. Borland was elected president of the Duval County Medical Society for 1950 at the regular meeting held on December 6. The officers who will assist the president in 1950 will include Dr. Charles F. Henley, president-elect; Dr. Elmer E. Leitner, vice president; Dr. Samuel M. Day, Jr., secretary and Dr. A. Judson Graves, treasurer.

At the meeting, Dr. Raymond R. Killinger, retiring president of the society, gave a short speech.

One of the first functions of Dr. Borland as the new president was to appoint his cabinet members.

Escambia

The 1950 officers of the Escambia County Medical Society were elected at the regular meeting in December. They are Dr. Jesse N. McLane, president; Dr. John C. McSween, Jr., vice president and Dr. Arthur J. Butt, Jr., secretary-treasurer.

Hillsborough

Officers elected to serve the Hillsborough County Medical Association for the year 1950 at the December meeting are Dr. David R. Murphey, Jr., president; Dr. Renfro R. Duke, president-elect; Dr. Harold G. Nix, vice president; Dr. Herschel G. Cole, secretary, and Dr. Joseph A. Pendino, treasurer. Members of the board of censors and committee chairmen were elected at the meeting.

Indian River

The Indian River County Medical Society held an election of officers at its regular monthly meeting in December to serve during the year 1950. Dr. Melton D. Council of Vero Beach was elected president, and Erasmus B. Hardee of Vero Beach was elected vice president. Dr. William L. Fitts, 3rd, was re-elected secretary-treasurer.

Jackson

At the December meeting of the Jackson County Medical Society, officers for the year 1950 were elected. Dr. James T. Cook, of Marianna was elected president, Dr. Jasper B. Dowling of Altha, vice president, and Francis M. Watson of Marianna, secretary-treasurer.

Lee

The following members were elected officers for the coming year at the regular meeting of the Lee County Medical Society in December: Dr. Walter B. Clement of Punta Gorda, president; Dr. Joseph D. Brown of Fort Myers, vice president; and Dr. Roscoe S. Maxwell of Punta Gorda, secretary-treasurer.

Leon-Gadsden-Liberty-Waukulla-Jefferson

Dr. J. Lloyd Massey is the newly-elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. John T. Benbow of Chattahoochee was elected vice president for 1950, and Dr. Edward C. Love, Jr., of Quincy was re-elected secretary-treasurer.

Madison

Officers elected to serve the Madison County Medical Society during 1950 include: Dr. Eugene D. Thorpe, president, and Julian M. Durant, secretary-treasurer.

Manatee

At the December meeting of the Manatee County Medical Society the following officers were elected to serve in 1950: Dr. Joseph A. Gibson of Palmetto, president; Dr. Millard P. Quillian of Bradenton, vice president; and Dr. Marjorie L. Warner of Bradenton, secretary-treasurer.

Marion

The following 1950 officers were elected at the December 21 meeting of the Marion County Medical Society: Dr. Richard C. Cumming, president; Dr. Jack M. Waldrep, vice president; and Dr. Bertrand F. Drake, secretary-treasurer, all of Ocala.

Monroe

The Monroe County Medical Society elected Dr. Herman K. Moore as its president for 1950. Other officers selected for the coming year are Dr. Joseph L. G. Lester, Jr., vice president; Dr. Wallace H. Mitchell, secretary and Dr. Allen S. Shepard, treasurer.

At a recent meeting held at the Monroe County Hospital, Key West doctors were privileged to listen to a talk by Brig. General Wallace H. Graham, M.D., U. S. A. F., personal physician to President Truman. Guests at the meeting included medical officers from the Naval Hospital, nurses and a visiting physician from New York City. Immediately preceding Dr. Graham's talk, Dr. Ralph Herz gave a paper on "Appendicitis in the Aged."

Nassau

Officers elected to serve the Nassau County Medical Society during 1950 include: Dr. David G. Humphreys of Fernandina, president, and Dr. John W. McClane of Fernandina, secretary-treasurer.

Orange

At the regular December meeting of the Orange County Medical Society, the following officers were elected for the year 1950: Dr. Hollis C. Ingram, president; Dr. Fred Mathers, president-elect; Dr. William S. Mitchell, vice president; Dr. Gerald W. Jones, secretary; and Dr. Joseph C. Hayward, treasurer.

Palm Beach

The following officers for 1950 were elected by the membership of the Palm Beach County Medical Society at the December meeting: Dr. Charles McD. Harris, Jr., of West Palm Beach, president; Dr. Ralph M. Overstreet, Jr., of West Palm Beach, president-elect; Dr. Alvin E. Murphy of Palm Beach, vice president; Dr. Cecil M. Peek of West Palm Beach, secretary; and Dr. Frederick K. Herpel of West Palm Beach, treasurer.

Pasco-Hernando-Citrus

Dr. S. Carnes Harvard of Brooksville is the newly-elected president of the Pasco-Hernando-Citrus County Medical Society. Other officers elected to serve with Dr. Harvard during 1950 are Dr. Gail M. Osterhout of Inverness, 1st vice president; Dr. Frank J. Farley of Dade City, 2nd vice president; and Dr. W. Wardlaw Jones of Dade City, secretary-treasurer.

Pinellas

The 1950 officers for the Pinellas County Medical Society are listed in the December Journal.

Polk

At its regular business meeting on December 14, the Polk County Medical Society held its annual election of officers. Those elected to office were Dr. Emmett E. Martin of Haines City, president; Dr. Wylie L. Tillis of Lakeland, vice president; Dr. John W. Vaughn of Lakeland, secretary-treasurer. Also elected were the various standing committee chairmen and members of the board of censors.

Putnam

Dr. Grover C. Collins was re-elected as president of the Putnam County Medical Society for 1950 at the December meeting. Dr. Lawrence G. Hebel was re-elected secretary-treasurer.

St. Johns

The newly-elected officers of the St. Johns County Medical Society are as follows: Dr. S. Raymond Cafaro, president; Dr. Robert D. Harris, Jr., vice president; Dr. Joseph A. Shelley, secretary; Dr. A. Clark Walkup, treasurer.

St. Lucie-Okeechobee-Martin

The newly-elected president of the St. Lucie-Okeechobee-Martin County Medical Society is Dr. Steve R. Johnston of Ft. Pierce. Other 1950 officers are Dr. Julian D. Parker of Stuart, vice president and Dr. Adrian M. Sample of Ft. Pierce, secretary-treasurer.

Sarasota

Dr. Talmadge S. Thompson of Venice will serve the Sarasota County Medical Society in the capacity of president for the year 1950. The officers elected to serve with him are Dr. A. Lamar Matthews, Jr. of Sarasota, vice president; and Dr. Millard B. White of Sarasota, secretary-treasurer.

Seminole

The officers for the year 1950 of the Seminole County Medical Society were elected at the December meeting. Dr. Charles L. Park was elected president, and Dr. Thomas F. McDaniel was elected vice president. Dr. Frank L. Quillman was again re-elected secretary-treasurer.

Suwannee

At the regular monthly meeting of the Suwannee County Medical Society in December, officers were elected for the year 1950. Dr. Irby H. Black was elected president and Dr. J. Dillard Workman was elected secretary-treasurer.

Volusia

The Volusia County Medical Society officers for 1950 are Dr. Eric H. Lenholt of Daytona Beach, president; Dr. William C. Chowning of New Smyrna Beach, vice president; Dr. Robert L. Miller of Daytona Beach, secretary-treasurer.

Walton-Okaloosa

New officers of Walton-Okaloosa County Medical Society include Dr. Allen A. Enzor of Crestview, president; Dr. Edgar H. Myers of DeFuniak Springs, vice president; and Dr. Arthur G. Williams, Jr., of Valparaiso, secretary-treasurer.

OBITUARIES**Charles Kramer Farber**

Dr. Charles Kramer Farber of St. Petersburg died on Dec. 6, 1949. He was 72 years of age.

A native of Ohio, Dr. Farber was born in Cleveland on Sept. 17, 1877 and received both his academic and medical training in that city. Upon graduation from the Cleveland-Pulte Medical College in 1902, he taught in that institution for four years. At one time he was city physician of Cleveland.

Following a severe illness, Dr. Farber located in St. Petersburg in 1913 and continued the practice of medicine there until the time of his death thirty-six years later. Locally, he was a member of the Mirror Lake Christian Church and of the Odd Fellows Lodge.

Dr. Farber was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association.

Julius Abraham Oshlag

Dr. Julius Abraham Oshlag of Miami Beach died suddenly on Nov. 9, 1949 at the age of 43 years.

Born in New York City in 1906, Dr. Oshlag was graduated from the New York University College of Medicine in 1930. He engaged in active practice in New York City and was on the staff of Post Graduate Hospital until he entered military service in 1942.

After receiving a medical discharge from the Navy in 1943, he entered the United States Public Health Service at Mobile, Ala., and served in that organization until January 1946. Learning that there was dire need for a physician in Key West, he then voluntarily took up practice there, having obtained his Florida license in 1943.

During the short time that Dr. Oshlag practiced his specialty of internal medicine in Miami Beach he was active in the Alton Road Hospital, St. Francis Hospital, Children's Cardiac Home and the newly developing Mt. Sinai Hospital. He was particularly interested in the Miami Heart Association and had for months worked on a brochure soon to be published by that association as a guide for persons with cardiac disease.

Dr. Oshlag was a member of the Dade County Medical Association and the Florida Medical Association, and was a fellow of the American Medical Association.

Surviving are the widow, Juliet Neustadt Oshlag, and two daughters, Dorothy and Frances.

Robert Eldon Repass

Dr. Robert Eldon Repass of Miami died on Oct. 27, 1949 at the Veterans Administration Pratt General Hospital in Coral Gables, where he had been a patient since May of that year. He was 67 years of age.

A native of Indiana, Dr. Repass was born in Augusta on Sept. 18, 1882. He received his medical degree from the Indiana Medical College, School of Medicine of Purdue University in Indianapolis in 1906 and practiced medicine in that city until he came to Ft. Lauderdale in 1926. Two years later he located in Miami and practiced the specialty of ophthalmology and otolaryngology there until his retirement more than three years ago. He served on the staffs of the St. Francis, Jackson Memorial and Victoria hospitals.

During World War I Dr. Repass served overseas as medical officer of the 301st Heavy British Tank Unit. A member of the American Legion, he also was affiliated with the Forty and Eight and the Veterans of Foreign Wars. He was a Scottish Rite Mason and a member of Murat Shrine Temple of Indianapolis.

Dr. Repass was a member of the Dade County Medical Association and held membership in the Florida Medical Association for twenty-four years, the last four years as an honorary member owing to ill health. He was a fellow of the American Medical Association and a member of the American Academy of Ophthalmology and Otolaryngology.

Survivors include the widow, Mrs. Claire Rentick Repass; a son, Robert E. Repass of Asheville, N. C.; three brothers, a sister and three grandchildren.

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On Data of Notable Interest**



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Annual Meeting of Southern Auxiliary

The 25th Anniversary Meeting of the Southern Auxiliary was held at the Sinton Hotel, Cincinnati, Ohio with the Campbell-Kenton County Doctors' wives of Kentucky as hostesses. The program included the executive board breakfast and a general meeting the morning of November 15, a beautifully appointed and served tea on the afternoon of November 15 with the hostesses serving, a general meeting and luncheon on November 16. The meeting closed after this luncheon and Mrs. R. C. Haynes, newly installed president, opened the new year with an executive board breakfast on November 17.

Mrs. Joseph Kelso, president, presided at all meetings and reported that she had visited wherever possible covering nine state meetings during her term of office. Reports of the officers and chairmen of committees showed an increased enthusiasm and participation in the projects of the Auxiliary.

The annual luncheon was honored with the presence of Mrs. David Allman, president of the American Medical Association Auxiliary, Mrs. Arthur H. Herold, president-elect of the American Medical Association Auxiliary, Dr. Ernest E. Irons, president of the American Medical Association, Dr. Elmer L. Henderson, president-elect of the American Medical Association, Dr. Oscar B. Hunter, president of the Southern Medical Association and Dr. Hamilton W. McKay, president-elect of the Southern Medical Association. Dr. Henderson



From where I sit
by Joe Marsh

Sure You Haven't a "Blind Spot"?

As I was driving down Main Street last Saturday, another car swung out right in front of me. It turned out to be Buck Blake. He wasn't going fast. It was just that he had something else on his mind at that particular moment.

Buck's really one of the nicest fellows I've ever known. But, sometimes he gets to day-dreaming on the road. He sort of gets a "blind spot" to what's going on about him!

Now, lots of normally considerate folks have their "blind spots." It could be anything from day-dreaming while driving a car to humming out loud at the movies.

From where I sit, it's mighty important to be on guard against your own "blind spots." The other fellow has a right to his "share of the road," too—whether it's having a taste for a temperate glass of sparkling beer or a desire to listen to some classical music if he wants to.

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and Mrs. Allman addressed the guests and urged the necessity of each county organization taking its part in the fight against socialized medicine. Dr. Henderson reminded us that he was not fighting nor were we fighting against socialization of medicine alone but against socialization of our entire life. Mrs. L. S. Thompson, Dallas, Texas, newly elected and installed president-elect and historian for the year gave a history of the 25 years of the organization and past presidents were recognized along with chartered members. The Southern Auxiliary acknowledged with grateful thanks the entertainment of the ladies of Campbell-Kenton County.

The Woman's Auxiliary to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society met on Thursday, November 10, at the Florida State Hospital with the Chattahoochee members as hostesses. Guest speaker for the afternoon was Julian Davis, psychologist at the Florida State Hospital, who gave a most interesting paper on "The Meaning of Physical Illness to Children."

The president, Mrs. M. R. Clements, reported on the board meeting she attended in Jacksonville. Plans are being made for a "Doctors' Day" program to be held in April.

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BOOKS RECEIVED

LIFE AMONG THE DOCTORS. By Paul de Kruif. Price, \$4.75. Pp. 470. New York: Harcourt Brace and Company, 1949.

Dr. Paul de Kruif, probably America's best known popularizer of medical science, remains the melodramatist in this his eleventh book on medicine. With characteristic breathless, emotional appeal which has impressed the public in the past, he presents in fourteen long chapters lively biographic sketches of research medicos, from Dr. Alvin F. Coburn investigating rheumatic fever to Dr. O. C. Wenger campaigning in wholesale fashion against venereal disease. He portrays them all as fighting heroes trying desperately to save lives despite the scheming of "villians in medical societies or high government places." In fact, he waxes well nigh maudlin at times over their life-saving in defiance of "medical authority," which authority, incidentally, he does not name. Naturally, he stirs the reader with tales of genius in conflict with chicanery, envy and obtuseness—the main protagonist often being the smugness of "organized medicine."

As with his past writings, this dramatic, fighting book will no doubt spur many patients to ask their physicians why they are not using the remedies and technics he extols—a kind of prodding not popular with the doctors. It may, of course, multiply the unsubmitive patients who think they know more than their physician does, and it may increase the clamor for new and improved remedies in the hands of obscure researchers.

Too, the book may "do much for the doctors," as Dr. E. L. Henderson, President-Elect of the American Medical Association, stated when endorsing it. Certainly it should stimulate the profession to make it impossible for an intelligent and sympathetic insider to make such a sincere and fervent attack. It could do so by leading its members to make "a major effort to educate medical and science writers in the whole truth of the physician's awesome responsibility for life and death."

Dr. de Kruif, himself not a physician—his Ph.D. is in bacteriology—has lived so long and so intimately in the world of medical research that he is now described as a pundit who dares to disagree with medical authority in matters of policy, and he has many times embarrassed the profession by spreading his enthusiasms for new discoveries to the millions prematurely from the doctor's viewpoint. Recently, however, he has offered to help the American Medical Association in its fight against socialized medicine, and the medical profession may well be glad to have an author of his achievements in the fight on the right side.

THE COMPLETE PEDIATRICIAN, PRACTICAL, DIAGNOSTIC, THERAPEUTIC AND PREVENTIVE PEDIATRICS. By Wilburt C. Davison, M. D. Ed. 6. Price, \$4.75. Pp. 300. Durham, N. C.: Duke University Press, 1949.

This uniquely arranged and comprehensive up-to-date digest of pediatric knowledge represents an effort to combine in one volume for ready reference the information usually found in several. Emphasis on symptoms and signs as clues, rather than on description, makes this sixth edition of this deservedly popular book of more practical value perhaps than a systematic textbook. The author, who is professor of pediatrics at Duke University School of Medicine and pediatrician at Duke Hospital, emphasizes the twofold nature of pediatrics: (1) the appraisal of normal children and the necessity of keeping them normal, based on a knowledge of growth, development and prevention, and (2) the recognition of ill children, their diseases and what to do for them.

This veritable storehouse of reliable pediatric information offers the progressive physician an invaluable aid. It has been aptly described as all a doctor needs to know about pediatrics and is intended for medical students, interns and general practitioners as well as pediatricians.

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 20, March 20. Vaginal Approach to Pelvic surgery, One Week, starting March 6.

OBSTETRICS—Intensive Course, Two Weeks, starting March 6, April 3.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Electrocardiography & Heart Disease, Four Weeks, starting March 13. Hematology, One Week, starting May 8. Gastro-Enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting March 6, May 15.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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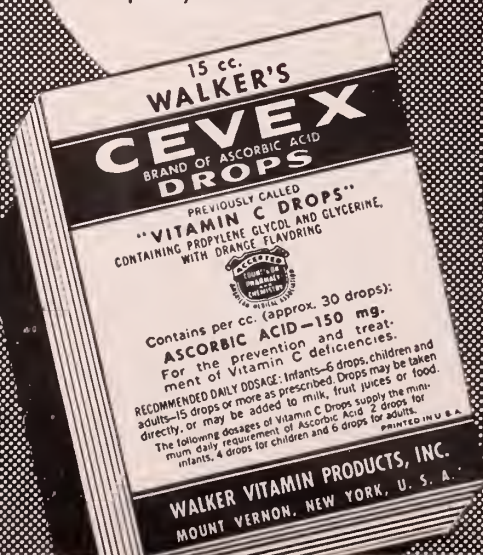
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GOLDEN JUBILEE WORLD TRIBUTE TO DR. SIDNEY V. HAAS.
By The Committee for the Golden Jubilee Tribute to Dr.
Sidney V. Haas. Pp. 38.

This book tells the story of the worldwide tribute paid to Dr. Sidney V. Haas of New York on the occasion of his completion of fifty years of medical practice. This noted pediatrician was honored at this time for pioneering contributions to pediatrics, particularly his discovery of the therapeutic value of the banana diet in the treatment of celiac disease and his introduction of the atropine therapy for the hypertonic infant. Contained in the book are a brief biographic sketch of Dr. Haas, a list of his published papers on pediatrics, excerpts from the speeches made at the luncheon in his honor, a list of the guests present, excerpts from some of the letters contributed to the Golden Book of Tributes and a complete list of those who sent them. The Committee for the Golden Jubilee Tribute to Dr. Sidney V. Haas, whose address is Room 609, 730 Fifth Ave., New York 19, N. Y., hopes that the little book will foster wider understanding of the importance of pediatrics and of Dr. Haas' great contributions to the field.

ACUTE LARYNGOTRACHEOBRONCHITIS. By A. Harry Neffson, M.D. Price, \$5.00. Pp. 197. New York: Grune & Stratton, 1949.

Although thirty years have elapsed since the medical profession was awakened to the realization that acute laryngeal obstruction—then known as "croup"—could be caused by infections other than diphtheria, there remains today much confusion and argument about fundamental conceptions of laryngotracheobronchitis. This book meets the need for a comprehensive and yet detailed description of its various aspects, dissipates some of the clouds of confusion at present prevailing and offers the puzzled practitioner a full and practical answer to his individual problems. It should enable the general practitioner, the pediatrician and the laryngologist to gain a clearer understanding of this disease and thus be better equipped to deal with it.

Whereas at one time patients with laryngotracheobronchitis were the sole responsibility of the laryngologist, the advent of the sulfonamides and the antibiotics has given impetus to the tendency for pediatricians to assume the direction in the handling of these patients. Accordingly, one chapter of the book is devoted to a discussion of the role and the limitations of the family doctor, the pediatrician and the otolaryngologist, with some practical suggestions for treatment in the home and warning signals of impending danger, which call for hospitalization and the help of an endoscopist.

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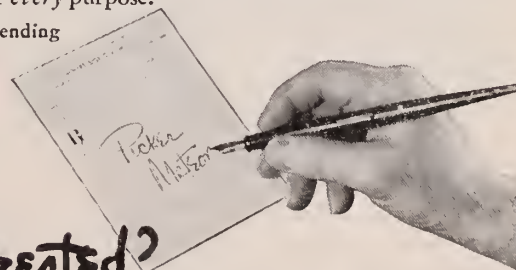
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March 6-9, 1950
GUEST SPEAKERS

Dr. Stuart C. Cullen, Iowa City
Anesthesiology
Dr. Francis W. Lynch, St. Paul
Dermatology
Dr. Moses Paulson, Baltimore
Gastro-enterology
Dr. Emil Novak, Baltimore
Gynecology
Dr. John Parks, Washington, D. C.
Gynecology
Dr. William Barry Wood, St. Louis
Medicine
Dr. William Dameshek, Boston
Medicine
Dr. H. Houston Merritt, New York
Neuropsychiatry
Dr. William J. Dieckmann, Chicago
Obstetrics

Dr. Parker Heath, Boston
Ophthalmology
Dr. Austin T. Moore, Columbia, S. C.
Orthopedic Surgery
Dr. Theodore E. Walsh, St. Louis
Otolaryngology
Dr. William Boyd, Toronto, Canada
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Dr. William J. Orr, Buffalo
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association.....	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts.....	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest.....	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Marianna
B-Northeast.....	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Ocala
C-Southwest.....	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Ft. Myers
D-Southeast.....	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	West Palm Beach
Florida Specialty Societies.....			
Allergy Society.....	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Chapter, Am. Acad. Gen. Prac.....	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.....	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of.....	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society.....	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Heart Association.....	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons.....	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry.....	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society.....	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of.....	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society.....	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society.....	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State.....	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society.....	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society.....	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society.....	A. Fred Turner, Jr., Orlando	Linus W. Hewit, Tampa	" "
Florida—			
Basic Science Exam. Board.....	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 3, '50
Dental Society, State.....	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association.....	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation.....	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	Jacksonville, Feb. 14, '50
Medical Examining Board.....	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, June 25-27, '50
Medical Postgraduate Course.....	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 26, '50
Medical Service Corporation.....	Leigh F. Robinson, Ft. Lauderdale	Terbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State.....	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State.....	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Public Health Association.....	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.....	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, March 30-31, '50
Woman's Auxiliary.....	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association.....	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session.....	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	
Southern Medical Association.....	Hamilton W. McKay, Charlotte, N. C.	C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association.....	Frank C. Wilson, Birmingham	Douglas L. Carnon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of.....	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
E. Hospital Conference.....	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	St. Petersburg, April 5-7, '50
Southeastern Allergy Assn.....	Oscar Swineford, Charlottesville, Va.	Kath. B. MacInnis, Columbia, S. C.	Columbia, S. C., Feb. 11-12, '50
Southeastern, Am. Urological Assn.....	James J. Ravenel, Charleston, S. C.	Russell B. Carson, Ft. Lauderdale	Edgewater Park, Miss., Feb. 1-5, '50
Southeastern Surgical Congress.....	R. J. Wilkinson.....	B. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
Gulf Coast Clinical Society.....	Sidney G. Kennedy, Jr., Pensacola	Arthur J. Butt, Jr., Pensacola	

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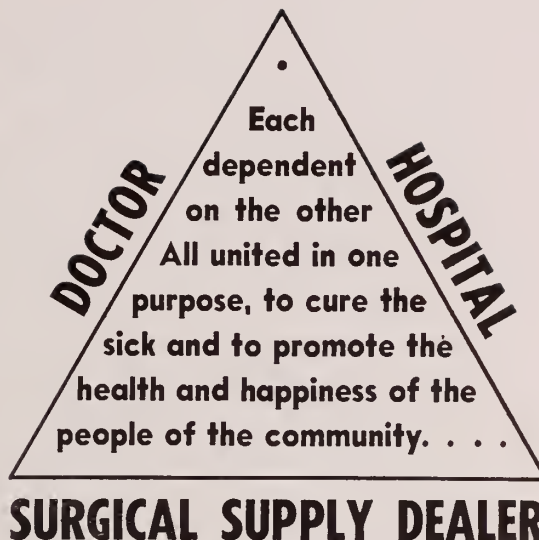
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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Hon.	Regular	
A	Bay	Daniel M. Adams, Jr., M.D. Box 593 Panama City	Jack Corbitt, M.D. Box 961 Panama City		0	15	A-1-50 William P. Hixon, M.D. Pensacola
	Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	1	63	
	Franklin-Gulf	Albert L. Ward, M.D. Port St. Joe	Donald H. Anderson, M.D. Wewahitchka	3rd Tuesday Odd Months	0	7	
	Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	0	18	
	Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	0	15	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		0	5	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	0	16	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	2	44	
	Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		0	6	
	Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		0	4	
	Taylor *Dicke-Lafayette	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	0	3	196
B	Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 331 W. University Ave. Gainesville	Henry H. Graham, M.D. 749 E. Main St., N. Gainesville	2nd Tuesday 8:00 P.M.	0	40	B-3-50 Charles C. Grace, M.D. St. Augustine
	Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	2	246	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	2	27	
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	1	8	
	Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	0	9	
	St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	1	13	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
	Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	0	14	
	Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	1	18	
	Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	4	130	
	Seminole	Charles L. Park, M.D. 109 W. 17th St. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	0	12	
	Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	2	51	568
C	Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	0	153	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	0	20	
	Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	0	11	
	Pinellas	Albert R. Frederick, M.D. 408 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	11	154	
	Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	1	24	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	DeSoto-Hardee- Highlands- Charlotte-Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	0	29	
	Lee *Collier, Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. McCrory Bldg. Punta Gorda	3rd Monday 7:30 P.M.	0	22	
	Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	1	75	488
D	Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	0	8	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
	Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	1	94	
	St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	0	11	
	Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	5	64	D-8-51 S. Marion Salley, M.D. Miami
	Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	11	504	
	Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Wallace H. Mitchell, M.D. 217 Duval St. Key West	2nd Thursday 8:00 P.M.	0	12	693



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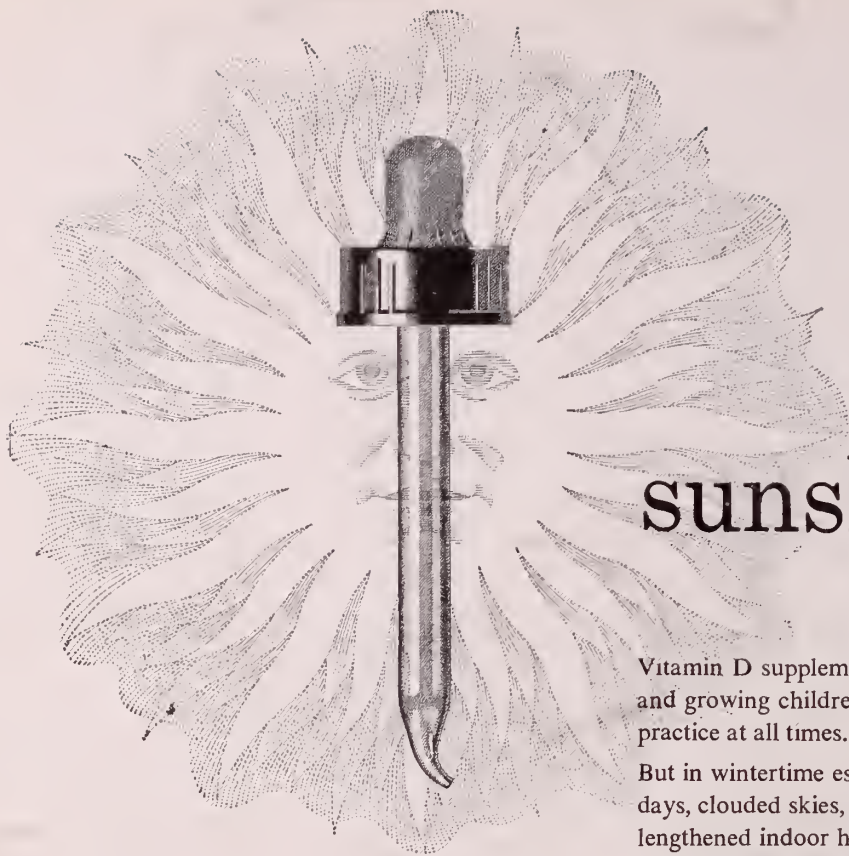


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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

MARCH, 1950

No. 9

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IN THIS ISSUE

Tuberculosis Control

Clarence M. Sharp



Dermatitis

Gordon B. Taylor



Pulmonary Diseases

Maurice Kovnat and Jack Reiss

Annual Meeting Program — Page 568



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CONTENTS

SCIENTIFIC ARTICLES

Progress in Tuberculosis Control in Florida, Clarence M. Sharp, M.D.	547
Dermatitis Due to Wearing Apparel, Gordon B. Taylor, M.D.	551
Role of the Roentgen Ray in the Diagnosis of Pulmonary Diseases: a Critique, Maurice Kovnat, M.D., and Jack Reiss, M.D.	554
Tick Paralysis: Report of a Case from Florida, Alvyn W. White, M.D., and Egbert V. Anderson, M.D.	561

ABSTRACTS OF MEDICAL ARTICLES

Drs. Donald F. Marion, Ned W. Holland, James M. Dell, Jr., John P. Michaels, Mason Trupp, H. Milton Rogers, Louis M. Orr, Fred Mathers, Thomas C. Butt, J. Maxwell Williams, Jr., W. H. Brooks and Sullivan G. Bedell	562
---	-----

EDITORIALS

Seventy-Sixth Annual Meeting	579
Notice to Delegates and Committee Chairmen	580
Aureomycin and Aluminum Hydroxide Gel	580
The Supreme Purpose of a Profession	580
The Meaning of Democracy	581

COMMENTARIES

New Name for Hygeia	581
New Building for Jacksonville Blood Bank	582
Participation in Politics Clarified	582

GENERAL FEATURES

Officers and Committees	576
Hollywood-by-the-Sea	567
Program of Seventy-Sixth Annual Meeting	568
Alton Ochsner, M.D., Guest Speaker	578
Your Blue Shield	582
Births, Marriages and Deaths	583
State News Items	583
Component Society Notes	585
The Technical Exhibit	586
Books Received	592
Schedule of Meetings	597
List of County Medical Societies, Presidents and Secretaries	598

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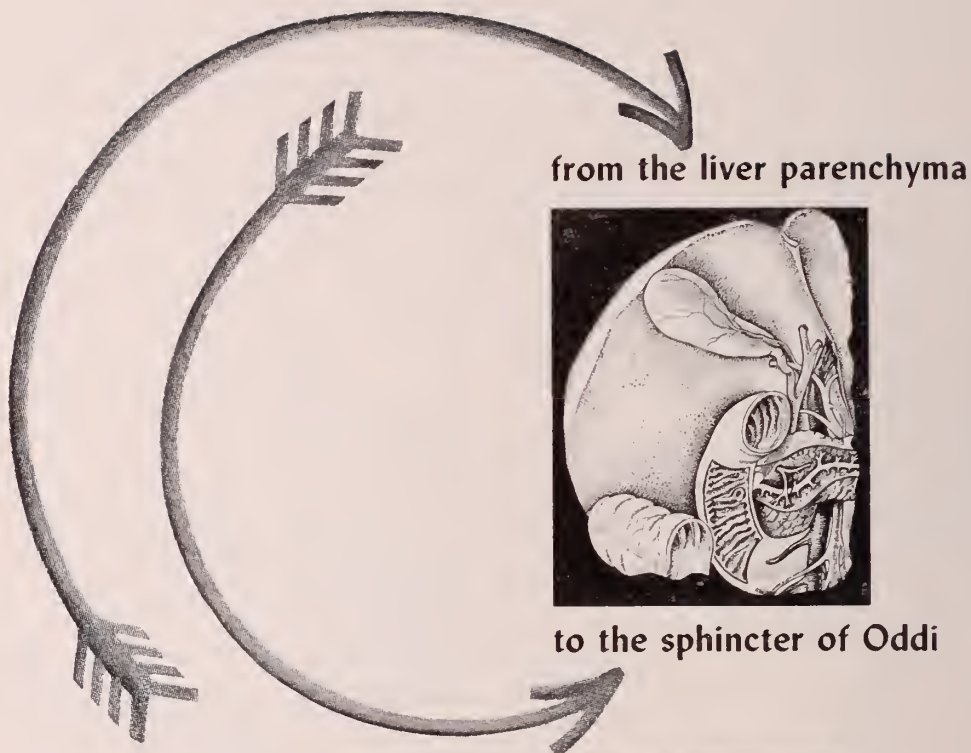
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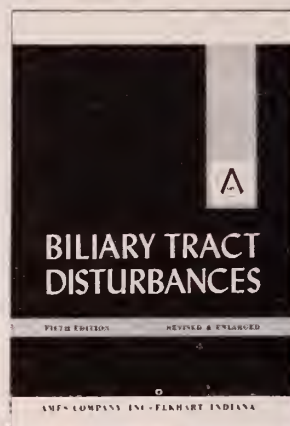
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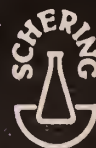
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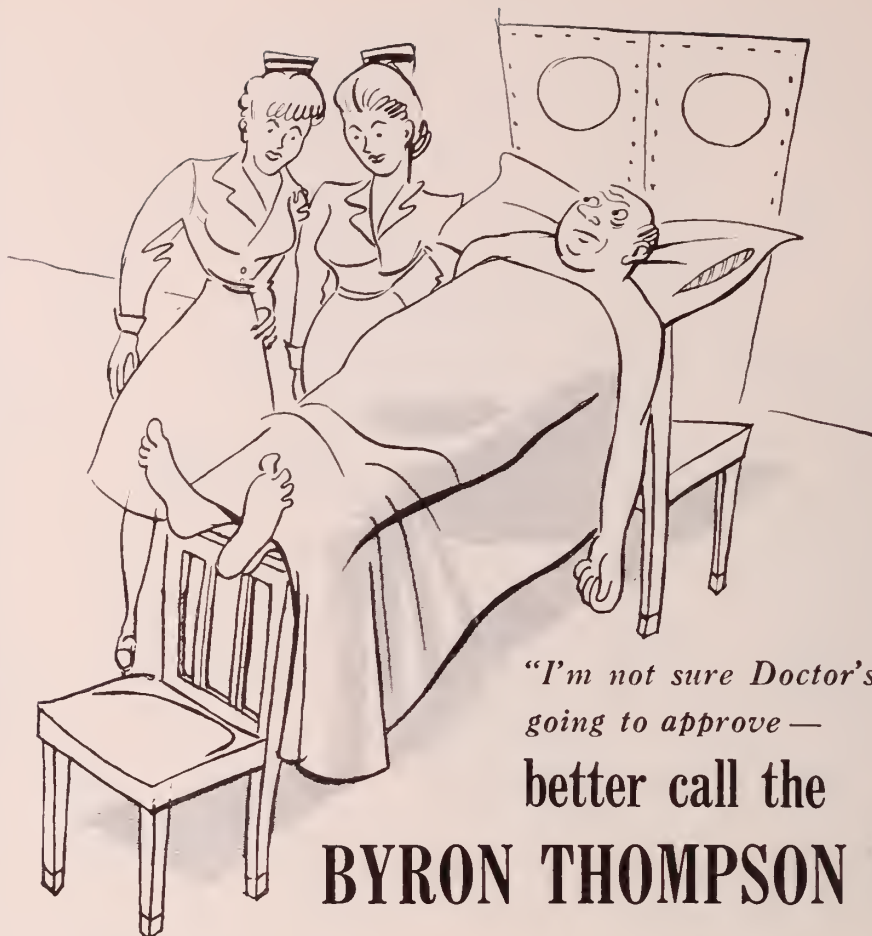
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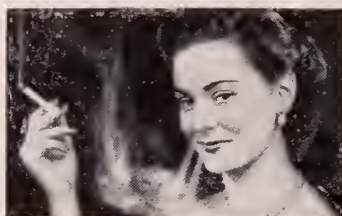


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* *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N.Y. State Journ. Med.*, Vol. 35, 6-1-25, No. 11, 590-592; *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (Apr. 2,) 1949

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Hamblen, E. C.: Some Aspects
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in General Practice,
North Carolina M. J.
7:533 (Oct.) 1946.

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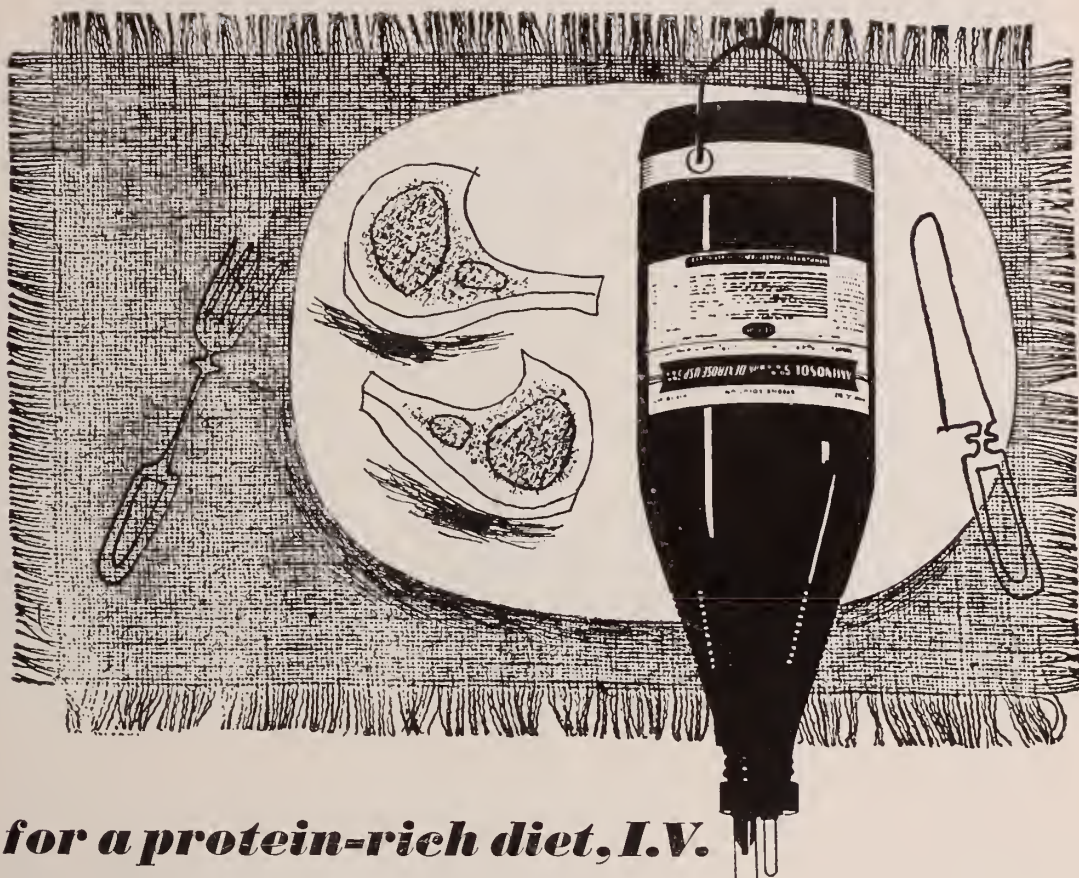


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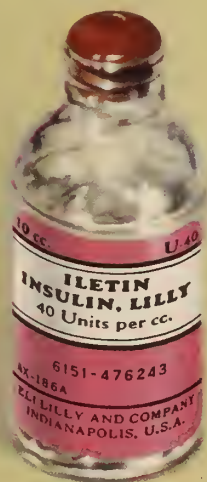
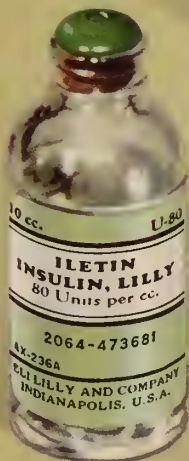
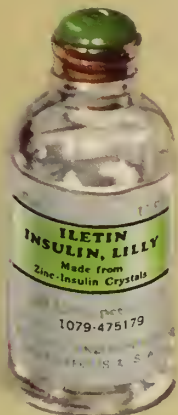
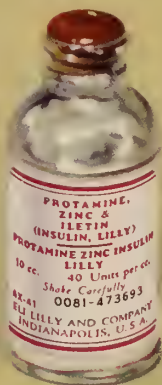
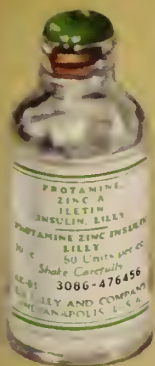
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Progress in Tuberculosis Control in Florida

CLARENCE M. SHARP, M.D.
JACKSONVILLE

The general activities of the Bureau of Tuberculosis Control have continued to increase, and as a result of the intensified efforts a larger volume of information was available this year than was reported in the 1947 annual report. This report will be written more or less in line with the 1947 report so that a comparison can be made concerning the volume of work performed, and the epidemiologic findings with regard to the tuberculosis problem in the state of Florida further clarified.

Death Rate

No analysis of the tuberculosis situation in a community would be complete without studying the death rate. As a contrast to 1947, the provisional figures show that there has been as much decrease in tuberculosis deaths during the year of 1948 as there was increase over the year of 1946. The total death rate for 1948, in spite of the fact that population estimates in the state as a whole have increased, shows that there were 720 deaths from tuberculosis in Florida as against 760 deaths during the year 1947. The mortality rate during the year 1948 has declined to 29.1 per 100,000 population as contrasted with a rate of 31.6 per 100,000 during 1947. This rate represents the lowest tuberculosis mortality rate in the history of Florida, and is lower than any other Southeastern state. In fact, it is considerably lower than the national average for tuberculosis.

It should be noted that the mortality rate for the white population in the state has reached the rate of 17.5 per 100,000 population, which in this group compares favorably with the best states in the country. The Negro mortality rate, however, still remains high, although there has been a decrease from 68.0 per 100,000 population during 1947 to 66.9 per 100,000 during 1948. The total deaths among Negroes have not shown nearly so

great a decrease as have those among white persons. During 1948, 388 Negroes died from tuberculosis as against 389 during 1947.

It is believed that the addition of the 500 bed sanatorium in Tampa, and the 200 bed sanatorium in Marianna, where advanced cases of the disease can receive the necessary isolation, is finally beginning to show results, since it has definitely been proved from a public health standpoint that tuberculosis rates can be decreased if adequate provisions are available to isolate the infectious cases of the disease.

Reported Cases

A rather intensive effort has been made during 1948 in a study of the morbidity from tuberculosis in the state. This has been made from several sources. One source was the reporting of the disease in clinics operated by the State Board of Health and by the local health departments. Another was the reporting from private physicians and general hospitals as well as by sanatoriums. Out-of-state notifications, death certificates and Veterans Hospitals as well as the newly organized Selective Service also provided sources of reports which have been analyzed.

During the year 1948 the tuberculosis cases reported by age, sex and stage of the disease were analyzed on punch cards by the number of cases per county and the number of deaths per county. In some instances, there were rather great increases in the number of cases reported for each death, but this is a relative figure since the population differences in many of the counties far outweigh the reported cases. For instance, in Hillsborough County there were 6.54 cases reported per each death from tuberculosis, while in Duval County there were only 2 cases reported per each death. In Dade County, which is the largest county, there were 4 cases reported per each death.

— Director, Bureau of Tuberculosis Control, Florida State Board of Health.

During 1948 there were 3,313 cases of tuberculosis reported in the state of Florida, which number shows an appreciable decrease over the 4,335 cases reported in 1947. The primary reason for this decrease in the number of cases reported is believed to be the fact that there were not nearly so many old cases newly reported for 1948. For instance, the annual report for 1947 showed that over 25 per cent of all cases reported to the State Board of Health were old cases which were previously known to some other source, but which were first reported to the health department. During 1948, however, practically all of the cases reported represent new cases of tuberculosis. For example, the new cases reported in 1947 were 3,251 whereas in 1948 there were 3,112, there being only 201 old cases newly reported, which account for the decrease in the number of cases reported.

An analysis of the source of reporting continues to show that there is a great increase in the amount of reporting from county and city health departments with a consequent decrease in the reporting of the disease by private physicians as well as in general hospitals.

There has been no appreciable reduction in the number of cases first reported by death certificate. Four per cent were reported by death certificate in 1947, and the same figure holds true for 1948. There have been fewer cases reported from Veterans Administration facilities, and also fewer

cases reported from other sources.

Another factor which concerns the reporting of cases is that in 1948 there was an appreciable increase in the number of cases first reported from state tuberculosis sanatoriums. This represents 7½ per cent of all the cases reported as against only 4 per cent during 1947.

In a detailed total breakdown of the number and percentage of tuberculosis cases by race and sex, the white male continues to occupy the highest position. Forty-six per cent of all cases reported were among the white males, and the white females averaged 28.5 per cent of all cases reported. In spite of the fact that the tuberculosis mortality rate among Negroes is about three and one-half times that of the white population of the state, which would lead one to assume that the morbidity among the Negroes would be higher, this is certainly not borne out by the facts. The morbidity among Negroes shows that 13.3 per cent of the cases reported occurred in males and 8.7 per cent in females, making a total of 22.0 per cent of all reported cases among Negroes. The exact significance of this finding is rather difficult to state. Whether it represents a certain racial susceptibility to the disease, or whether it represents strictly an economic factor is one of those intangible factors which certainly cannot be determined without a considerable amount of controversy. It could be entirely due to the fact that

CHART I

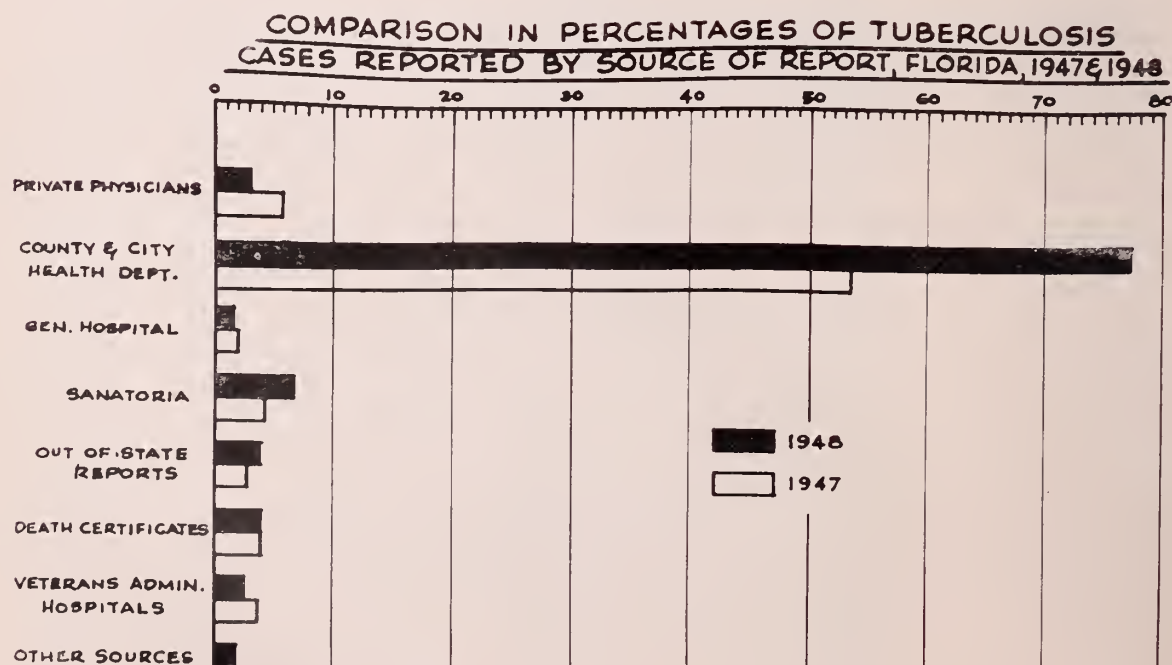
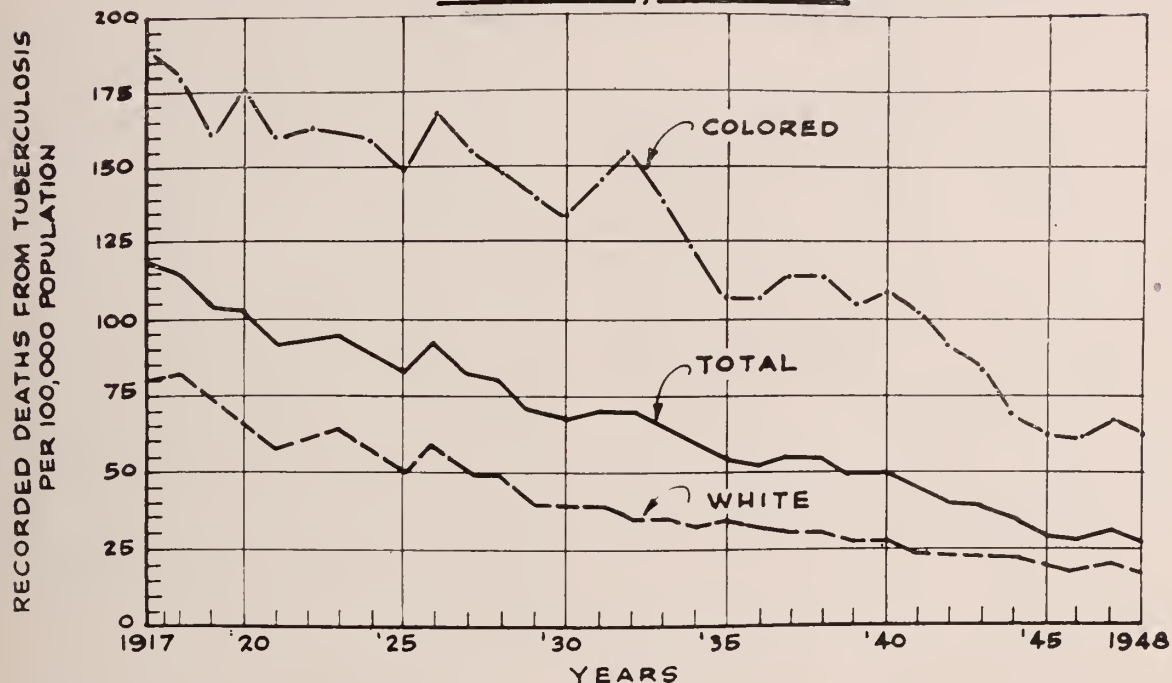


CHART II

TUBERCULOSIS DEATH RATES, BY COLOR
FLORIDA, 1917-1948

the diagnosis is established in fewer Negroes than it is in the white population group.

It will again be noted, as would be expected, that the largest number of cases continue to be reported from the larger county health departments where more people live, but it should also be pointed out that the mortality rates reported by these larger health departments are higher. The largest number of cases reported was from Dade County, where 499 new cases were reported; in Hillsborough County, 484 new cases were reported; in Orange County, 356; in Palm Beach County, 381, and in Duval County, 339.

It is interesting to observe in studying the morbidity of tuberculosis that in Palm Beach County, which has a new health department, there were 9 cases reported for each recorded death, and in Orange County there were 7 cases reported for each recorded death; Hillsborough County reported 6 cases for each recorded death, while Dade County reported only 4 cases for each recorded death, and Duval County reported 2 cases for each recorded death.

An analysis of the data shows that the highest incidence of tuberculosis cases reported is in the age group from 45 to 54, and the second highest in the age group from 35 to 44. This finding

corresponds fairly well with the mortality figures for the same age groups.

There is no striking difference between the percentage of the total cases reported for 1947 and 1948 in either the white or Negro population. There were, however, during 1948 a slightly larger number of white males reported and a slightly smaller number of Negro males and females.

An analysis of the Central Case Register shows that 34 of the more populous counties have operating case registers at the present time which are duplicated in the state office. These give the number of active cases, the number of questionably active, the number of inactive, and those in which the patients are in sanatoriums. The cases represented in the Central Case Register have increased from 7,417 as of Dec. 31, 1947 to 8,850 as of Dec. 31, 1948. This increase shows that better controls have been established over the cases in the state.

The number of patients with positive sputum who are residing in their homes is also shown. There were 871 patients with positive sputum at home and 2,033 with undetermined sputum in whom the disease was considered active. There were also 503 patients residing at home with negative sputum in whom the disease was considered

active. There were also 831 patients in the home in whom it was considered as questionably active. The known cases thus show that there are potentially 4,238 persons who possibly need hospitalization who are not receiving treatment.

Diagnostic Clinics

In all of the permanent diagnostic clinics in local health departments as well as the itinerant clinic operated by the Bureau of Tuberculosis Control there was a considerable increase in activities over 1947. During 1947 there were 9,434 large (14 by 17 inch) roentgenograms read by the Bureau of Tuberculosis Control, received from local health departments, from private physicians for consultation, from the itinerant clinic, and from tuberculosis and health associations. During 1948 this service has increased notably to 13,538 total roentgenograms interpreted. Sixty per cent of all large roentgenograms read during 1948 were initial roentgenograms and 39.5 per cent were subsequent or follow-up roentgenograms.

Of the roentgenograms interpreted, approximately 18 per cent showed evidence of tuberculous disease, and an additional 8.5 per cent showed evidence arousing suspicion of tuberculosis. In 1947 23 per cent of all roentgenograms examined showed evidence of tuberculous disease. In addition to the tuberculous pathologic change demonstrated on the roentgenograms read in 1948, 4.6 per cent showed evidence of disease other than tuberculosis. It is rather significant that of all the patients examined, in 322, or 2.4 per cent, there was evidence of far advanced tuberculosis, while in 1,460, or 10.8 per cent, there was evidence of minimal pulmonary tuberculosis on large roentgenograms. These figures are in decided contrast to previous ones and to the type of patient previously admitted to tuberculosis hospitals where approximately 70 to 80 per cent of all patients admitted were in the advanced stages of the disease. There were, however, fewer cases of minimal tuberculosis detected in clinic and consultation roentgenograms during 1948 than in 1947.

Mass Case Finding

The principal activity of the Bureau of Tuberculosis Control during the year 1948 was in the field of mass survey by X-ray, with the use of portable and mobile 70 mm. X-ray equipment which we have continued to concentrate on community-wide services.

During the second full year of operation of the four mobile and portable survey units carried

into communities by the State Board of Health, and the two stationary X-ray units operated by the Dade County Health Department and the Hillsborough County Health Department as well as mobile units operated by the Dade County Tuberculosis Association, the Polk County Health Department, and the Orange County Tuberculosis and Health Association, there were 415,599 adults of the state of Florida examined. This number represents approximately 20 per cent of the population of the state and is an increase over the 315,696 roentgenograms made during the year 1947. During 1948 a total of 1,306 definite cases of tuberculosis and 3,167 cases suggestive of tuberculous pathologic change were demonstrated. In addition, there were 2,332 persons in whom disease other than tuberculosis was demonstrated.

As was the case in 1947, a great deal of the credit for the large number of roentgenograms is to be given to the Florida Tuberculosis and Health Association and the county Tuberculosis and Health Associations, whose personnel participated wholeheartedly in a cooperative effort for community organization.

The Florida Tuberculosis and Health Association continues to pay a part of the salary of one of its field secretaries who spent the greater part of her time in organizing communities for the survey services. We are certain that any increase in activities that has been brought about was due to a great extent to the efforts of this organization.

Tuberculosis Activities in Counties

The Monthly Activity Report of the Bureau of Local Health Services shows that there were 19,704 clinic visits made during 1948. This is a slight increase over the visits made in 1947. This

CHART III

PERCENTAGE OF TUBERCULOSIS CASES
REPORTED, BY AGE GROUPS, FLORIDA 1948

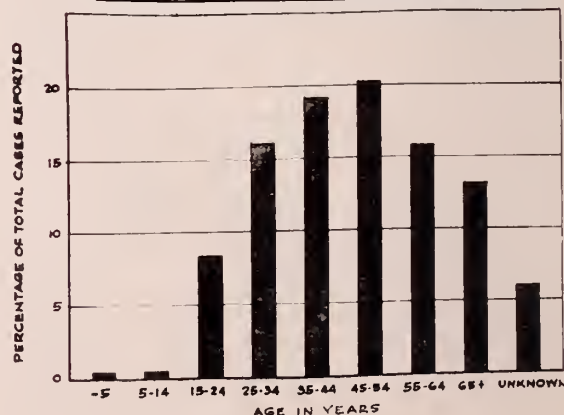
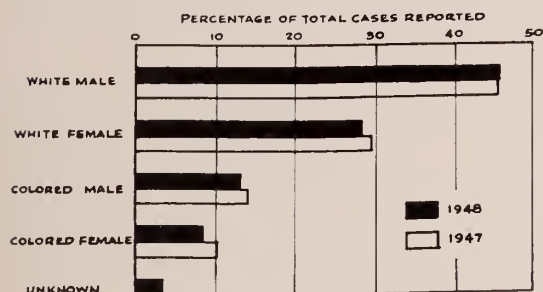


CHART IV

Summary

COMPARISON OF PERCENTAGE OF TUBERCULOSIS CASES REPORTED BY RACE & SEX, FLORIDA, 1947 & 1948



report also reveals that there were 25,789 field nursing visits made, approximately the same number as in the preceding year. In addition there were 9,038 office nursing visits made, which is a great increase over the 5,940 office visits made in 1947. Also in 1948, there were 1,141 patients hospitalized through the local health departments, while in 1947 there were 1,065 patients hospitalized through this source.

The foregoing report illustrates with a fair degree of accuracy the progress that has been made in the public health aspects of tuberculosis case finding and in a study of the extent of the tuberculosis problem in Florida.

There still remains, however, the old problem of isolation and adequate hospitalization. The tuberculosis mortality has shown a decided decrease over the preceding year, which we believe can be explained to a large extent by the addition of some 700 beds for the isolation of the infectious cases of the disease. This provision, however, is not adequate since there are known to be potentially 4,282 patients who need hospitalization. The ultimate control of tuberculosis in Florida, therefore, would seem to resolve itself into a relatively simple formula, and that is to provide a bed for the isolation and treatment of every known case of tuberculosis in the state, needing treatment.

Box 210.

Dermatitis Due to Wearing Apparel

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Dermatitis from wearing apparel is rather frequently encountered in medical practice and cases of this type form an interesting subdivision of the large field of contact dermatitis. Under this heading may also be included instances of dermatitis produced by jewelry and the various metal, leather and plastic accessories that are worn on the body with about the same regularity as the clothing.

Dermatitis from these various sources may sometimes be caused by friction from rough material, such as a coat collar, or the chafing from tightly fitting garments or improper shoes. In such instances the patient usually makes his own diagnosis and adopts corrective measures.

The cases that come to the attention of a physician, however, are almost always the result of an allergic response to substances or materials which are commonly harmless. This sensitivity does not usually become manifest as a skin rash until sev-

eral days after the offending article of clothing has been worn. Occasionally weeks or even months elapse before dermatitis develops. This variable interval may be regarded as the incubation period during which skin sensitivity develops following the initial exposure.

The skin eruptions produced vary over a wide range, from mild erythemas to the more severe vesicular or weeping types of inflammation. Itching is almost constantly present while constitutional symptoms are rare. The dermatitis always begins on the part of the skin in contact with the irritant, and here it is usually most severe. It may remain confined within this area, may assume the shape or outline of the contact irritant, or may spread beyond its original site. In especially sensitive persons a toxic eruption may appear on distant parts of the body, or may even become generalized.

The classes of materials involved in dermatitis

caused by wearing apparel include furs, natural and synthetic fabrics, rubber, leather, metals and plastics. These, together with all the dyes and other chemicals used in their preparation, provide a large total of substances which are eligible to sensitize the skin.

Furs are a well recognized, but rather infrequent, cause of contact dermatitis. The best known irritant commonly present in furs is a dye, paraphenylenediamine. Black furs, in which this dye has been completely oxidized, rarely produce a dermatitis. The lighter-colored furs, in which this dye is incompletely oxidized, are the most frequent offenders.

Wetting of the fur by water or perspiration greatly increases the possibility of dermatitis by virtue of the solvent action on poorly dyed fur. Persons in whom a dermatitis develops from furs can frequently date its onset to a snow or rain-storm in which the fur became wet.

The skin eruption commonly begins beneath the chin or on the sides of the neck and may spread to involve adjacent areas on the face, ears or upper sternal region. With fur sleeves or gloves, the wrists may be affected.

Dermatitis from the various natural and synthetic fabrics in dresses, suits, coat linings, under garments, stockings and other apparel is encountered rather frequently. While the irritant in these garments is sometimes the dye, it more often is one of the finishes. Finishes are chemicals that are placed in cloth to give it luster, better appearance and wearing qualities, and the ability to hold a crease or to prevent runs. Some of these finishes are removed by washing. Removal in this way explains why certain new garments may at first be irritating and subsequently be well tolerated after they have been cleaned. When the dye is the irritant, frequently it is easily removed from the garment by friction or perspiration and thus leaves the skin.

The location of the dermatitis on the body, a history of its starting point, and sometimes the artificial-looking pattern it produces on the skin materially aid in the detection of the offending garment. Dresses tend to produce dermatitis where they rub the skin, where they fit the tightest or in areas where there is the most perspiration. These locations are most often the sides of the neck and the axillary regions. Usually a dermatitis caused by a dress is limited on the front and back of the chest by the top of the slip or

brassiere, which serves to protect the underlying skin below this level. The lower border of dermatitis on the arms may suggest that the irritating garment had long or short sleeves. In women, dermatitis from a sweater or coat lining may only affect the arms distal to the level where the skin is protected by the underlying sleeves of the dress.

Such characteristically shaped areas as those covered by a brassiere, undershirt, half-lined coat, gloves and stockings readily suggest the cause when a dermatitis is confined to them. Dermatitis from underwear shorts in men usually is most severe on the genitalia.

Some garments may be composed of two different kinds or shades of cloth, or may have straps or linings, any one of which may be the cause of a dermatitis. Unless such articles of clothing are being worn at the time of examination, the diagnosis may easily be missed.

Woolen garments produce itching in a great many people. During the cold months of the year when woolen clothing is worn next to the skin, dermatitis from wool commonly occurs. The eruption tends to be diffuse or patchy with the skin having a dry, dull red, rough, chapped appearance. It is observed frequently in soldiers during the months when woolen uniforms are required. The condition is usually most severe on the legs, possibly because friction is generally greater there.

Rubber is included in a number of articles of clothing such as girdles, garters, elastic straps and belts, and these articles may produce a dermatitis from their rubber content. Rubber dress shields, which are worn over the axillas to protect the dress from perspiration, have occasionally caused an axillary dermatitis. Rubber gloves may cause dermatitis of the hands. The gloves can occasionally be rendered nonirritating if they are soaked for a few minutes in an alkaline solution, such as 5 per cent sodium hydroxide, or sodium carbonate. This removes some irritating compounds which are commonly used in the process of curing the rubber.

One of the most important types of dermatitis from wearing apparel is that caused by shoe leather. It is probably much commoner than is generally recognized and may sometimes give rise to prolonged disability. Many of the cases in which dermatitis of the feet persists for weeks or months and fails to respond to fungicidal remedies are in reality instances of dermatitis caused by shoe leather. Their identity as such is often concealed by secondary infection or dermatitis arising

ing from overtreatment. A detailed history of where the eruption began on the feet, its date of onset and the date of purchase of new shoes will frequently lead to a correct diagnosis.

The conditions of friction, warmth and perspiration on the feet are ideal for the transfer of irritants from the shoe leather to the skin. Most commonly, dermatitis from shoe leather begins on the dorsal surface of the big toe and it tends to be less pronounced over the more lateral toes. It is usually bilateral and symmetric, but the degree of severity is not always the same on both feet. The spread of the dermatitis is predominantly over the tops of the toes and dorsal surfaces of the feet. The soles and toe interspaces are relatively unaffected. This involvement is in contrast to that of fungus infections, which more particularly affect the skin between the toes and the plantar surfaces.

Shoes usually have two or more kinds of leather or cloth lining, which run along the sides of the feet and surround the heels. Dermatitis due to one of these lining materials will often be confined to the area where the lining covers the foot and hence it may present straight, angulated, or smoothly curved borders which give an artificial appearance. This in turn serves to identify the offending part of the shoe. In two-toned sport shoes, the dermatitis may be limited to the skin beneath one of the colored leathers, and thus form a bandlike pattern across or around the foot. When the tongues alone cause dermatitis, the shape of the areas on the dorsa of the feet will immediately suggest the cause. Shoes that have been treated by formaldehyde vapor or fungicidal powders may irritate because of these chemicals.

Once the offending shoes have been identified and discarded, a repetition of the experience can usually be prevented if the patient is advised to buy shoes of a different color and of another brand.

Dermatitis due to leather occasionally is caused by a hat band. The rather sharp outline of the dermatitis across the forehead suggests the cause, and in some cases the eruption extends within the hairline, above the ears, and encircles the head. Leather wrist watch straps produce a characteristic bandlike area of dermatitis, as does also the leather covering of a truss or its belt.

Articles made of metal such as wrist watches, rings, ear rings, necklaces, bracelets and the like occasionally produce a dermatitis where they touch

the skin. In most of these instances nickel is the offending substance, since many such articles are nickel-plated. White gold is an alloy of gold, copper and nickel, and its occasional irritant properties are usually due to its nickel content.

Spectacle frames frequently contain nickel, and the dermatitis caused by them is commonest behind the ears where the bows fit the tightest. Sometimes, also, the area in front of the ears, or where the metal touches the bridge of the nose, will be inflamed. A change to spectacle frames of plastic or some other material is a simple remedy.

Dermatitis from nickel-plated buckles, garters and zippers may occur where these metals contact the skin. Some of these localized patches can prove puzzling as to their origin unless the details of women's clothing are remembered. Common sites are the back of the lower part of the neck where the zipper of a dress touches the skin, small areas on the upper part of the chest anteriorly where the metals on the straps supporting a brassiere are located, and the back of the thighs where metal garters are frequently placed. An eruption on the inner side of the left arm has been produced by intermittent contact between the skin and an uncovered zipper on the side of the dress.

Plastic substitutes for metal or leather are occasional reasons for contact dermatitis on various parts of the body.

The contents of the pockets must be considered when a patch of dermatitis is present on the thighs, buttocks or chest, corresponding to the positions of the overlying pockets in the trousers or shirt.

The dark brown striking surface on safety match boxes contains a phosphorous compound that is an occasional skin irritant. When this dusty material infiltrates the cloth of the pocket, a dermatitis is usually produced on the genitalia, as well as the thigh. It may be necessary to put in a new pocket if traces of this irritant are to be completely removed.

Leakage of fluid from cigarette lighters can wet the pocket and cause a dermatitis. A leather wallet carried in the hip pocket is sometimes the cause of a dermatitis on the buttock. This is more likely to occur in hot weather when the pocket is wet with perspiration. Various other articles carried in the pockets are sources of dermatitis on rare occasions. Patch tests with the suspected articles or their transfer to another pocket are the best means of proving such a cause.

Conclusion

Successful treatment of contact dermatitis from wearing apparel depends in all cases on the discovery and removal of the causative irritant. The detection of irritants of this nature is usually an easier matter than in the case of contact dermatitis from many other causes because in dermatitis of

this origin the shape or partial outline of the contact irritant is often imprinted on the skin. Recognition of unusual symmetry or unnatural shapes or artificial-appearing features in a skin eruption will frequently lead to the correct diagnosis in cases of this nature.

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Role of the Roentgen Ray in the Diagnosis of Pulmonary Diseases: a Critique

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The discovery of the roentgen ray by Roentgen more than half a century ago was rightfully hailed as one of the greatest boons to mankind. Its use over the years has afforded the profession, among many other advantages, an excellent tool for the investigation of pulmonary diseases. With proper technical control the assistance a physician can derive from this modality is directly proportional to his visual acuity, his training and his experience. But regardless of his proficiency in all these three branches, he must be constantly aware that the film, no matter how perfect technically, is only a reflection of varying densities, and not a photographic reproduction of the disease state. Unfortunately it is apparent that we have not adhered to this basic principle.

Harrison¹ aptly stated that the avalanche of material things has blunted our thinking to such a degree that we have confused the symbol with the thing it represents. Surgical exploration is mistaken for treatment, diseases are mistaken for patients, histologic slides for diseases, x-ray apparatus for radiographs, and radiographs for diagnosis. As we view the processed films, we believe we are looking at tuberculosis or cancer, forgetting that no disease has an exclusive monopoly of a particular tissue change which is reflected on the film in the form of lights and shadows. This attempt to tie up disease and diagnosis by a simple mechanical short cut has not brought the two any nearer together. In fact we are having greater dif-

ficulties in prompt and accurate diagnosis of pulmonary lesions than our forebears did before the advent of the roentgen ray.

The overabundance of confidence in and reliance upon roentgen examination, which we appear to have inherited, may have been justified a generation or more ago when the field of pulmonary diseases was greatly circumscribed. Tuberculosis, then the major chronic disease, was readily recognized by means of this procedure, and could be simply differentiated from the handful of pulmonary problems on the basis of its presence in the upper lobes of the lungs. At least that was the common teaching at that time. Today we can hardly employ its predominance or its location as a means of identification from other pulmonary diseases. As its frequency has diminished, the incidence of the lesser and many totally unknown lesions of previous years has greatly increased. Cancer of the lung is not the rarity it once was, but is rapidly climbing into first place among the malignant diseases. Compensatory pulmonary lesions of all varieties are becoming more prevalent with new industrial hazards. Hamlin² listed forty-six harmful dusts that may affect the bronchopulmonary system of workers in various ways. Mycotic infection is a fertile field of pulmonary pathology developed since World War II. Viral and rickettsial lesions are coming to our attention more frequently.

In all these conditions the gross morbid changes of inflammation, exudation, and tissue destruction and formation play a variable part, and it is these

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changes that are portrayed on the roentgenogram, in a great variety of lights and shadows. No specificity of pattern is encountered in any one particular disease. The complexities of the patterns and the difficulties of untangling the maze are well illustrated by Garland³ who listed eighty-five different pulmonary conditions that were mistaken for tuberculosis from the roentgenogram. Another example of its fallibility for the quick solution of the pulmonary problem of today may be observed at the popular roentgenologic conferences of the convention and meeting hall. It is common experience to find that the interpretations are often as numerous and varied as the opinions expressed, each interpreter believing he has the correct diagnosis.

The problem of incorrect pulmonary diagnosis may have implications of a serious nature besides the purely medical. This fact is readily evident when one notes the increasing tendency to hold physicians, institutions and government agencies legally responsible for the roentgen interpretation. The hazards of exposure to the physical plant have been replaced by the liability inherent in the written report. Trostler⁴ cited a case in which a physician and the hospital were held liable for an error in roentgen interpretation. There is a case pending in a federal court⁵ in which a discharged soldier is suing the government for \$100,000 because of failure to diagnose correctly pulmonary tuberculosis from the discharge film, thus permitting him unknowingly to expose his wife and child to the disease, which they contracted. With the passage of the Federal Tort Claims Act the liability of the physician to malpractice suits has been greatly increased. The fallacy of unduly relying on roentgen reports for the diagnosis is further high-lighted by the many conflicting cases appearing in nonjudicial courts such as compensation, veterans' adjudication, employment, and retiring boards. As a result of conclusions drawn from reports from these sources, unsubstantiated by realistic clinical evidence, millions of dollars are unjustifiably paid out in the form of benefits and medical services. Even if subsequent evidence is introduced that completely negates the roentgen report, the difficulties that stand in the way of correcting the mischief are often insurmountable, particularly if a lay person or organization is involved in the controversy.

With the increased tempo of miniature radiography the harm that can result from the misinterpretation of such roentgenograms becomes

greatly augmented. One of us (M.K.),⁶ in commenting on the report of Birkelo and others⁷ of over 20 per cent error in the interpretation of survey roentgenograms, suggested that the margin of error could be appreciably reduced if no attempt were made to provide a specific diagnosis, grouping the findings instead into broad categories. Mark⁸ reviewed 40,000 consecutive chest roentgenograms and suggested only two interpretations from the radiograph, apparently normal, and apparently abnormal, as a means of reducing the otherwise high incidence of wrong diagnosis resulting from the radiographic interpretation.

In the search for causes of the frequent delays and errors in pulmonary diagnosis, it will be helpful to examine the present approach to the pulmonary problem. The usual procedure in practice today is to listen to the patient's chief complaints, make a cursory physical examination, and proceed to the roentgen studies. These studies are made the focal point in the search for the diagnosis, with the physician utilizing past experiences to translate the shadows into specific disease states. This common practice of working from the roentgenogram back to the disease is patently false. It sets off the investigation on the wrong road, delegates to the roentgenogram the function of specificity of which it is not capable, depresses the other branches of the investigation and distorts the entire clinical picture.

Essential Steps in Diagnosis

To overcome this evident and common weakness in pulmonary diagnosis the physician must approach the problem from the opposite direction, the clinical aspect, attacking each branch of the investigation in an orderly procedure and delegating to each its rightful importance. A detailed and complete history is therefore the first essential. There is much that the patient can relate that may be helpful to the diagnosis. We often realize the value of a complete history too late and have to go back time and again to gain important information. This necessity tends to confuse rather than clarify the picture. It is better to obtain the complete story at the outset. The clue to the presence of the pulmonary lesion may lie in some pertinent fact that can only be revealed by critical questioning. Certain mycotic infections are present only in restricted areas, and unless a residence in one of these localities is uncovered, no matter how brief and unimportant it may appear to the

patient, the true nature of the lesion may not be disclosed for some time, if at all. The pulmonary lesions of industrial origin can often only be diagnosed if a thorough occupational history is obtained. At other times the patient himself may stress a significant subjective complaint that only the sympathetic and close listener will appreciate. The pain of bronchial carcinoma, for example, may be the only significant lead to an early diagnosis of this grave condition. When Howard Lilienthal, the pioneer thoracic surgeon, admonished the physician "to listen," he meant to the patient's story, not to rales or breath sounds.

But rales and breath sounds are also important, and the physical examination should take its rightful place in the investigation of every pulmonary problem. Physical diagnosis is rapidly becoming a lost art, yielding place to mechanical short cuts in this busy age of time-saving. The elimination of the five senses and the neglect of our powers of observation have deleteriously affected the proficiency of pulmonary diagnosis. A simple glance at the ailing patient can often give us more information than hours of pondering and arguing over roentgenograms. Many a case is thus discussed in his absence with various opinions rendered. When he is brought into view, however, preformed judgments are hastily changed. Dyspnea, cyanosis, cachexia, fetid odor, and partial interference with ingress and egress of air through the airways are not written on the film, but they are vividly portrayed by physical contact with the patient and can be extremely important to the correct diagnosis. The stethoscope is still the greatest aid in recognizing such conditions as asthma, bronchitis, bronchiectasis and bronchopneumonia, in all of which a profusion of physical signs and generally a paucity of roentgen changes are present. If nothing else, the physical examination can be corroboratory of information obtained by other means and thereby aid in the final diagnosis. To neglect physical diagnosis is to neglect an important branch of the practice of medicine.

Following the detailed history and the careful physical examination, thorough laboratory investigation of the problem should be carried out. Any procedure that may aid in the diagnosis should be performed. The help and information that can be obtained from this source will depend in large measure on the organization and efficiency of the laboratory. Today the richness of the field of chest diseases and the demands for an exact and

early etiologic diagnosis compel this branch of investigation to widen its sphere of usefulness and develop its facilities to the highest possible degree. Bacteriologic studies for the isolation and identification of specific agents must be more widely employed. Workers should be trained in the newer methods of cytologic investigation. But no matter how noteworthy the assistance such procedures may provide, the results must always be substantiated by other observations of the clinical picture. To rely wholly upon a single laboratory finding, uncorroborated by other evidence, is as harmful as accepting a radiographic reproduction for the final diagnosis under the same circumstances.

Following the completion of these studies, the clinician should review all the pertinent findings and come to a decision as to the probable diagnosis in the case, listing the various conditions which must be considered in the differential diagnosis. It is at this point that the appropriate roentgen studies are indicated. These may consist either of conventional roentgenography in the various planes and positions, or they may include such special procedures as stereoroentgenography, tomography, bronchography and bucky films, depending on the observations of the clinical investigation. The material thus obtained may be scant in useful information, or it may be extremely abundant and valuable. But no matter of what the data accumulated by means of roentgen studies may consist, they must be carefully and closely scrutinized and viewed as patterns of changing densities brought about by changes in gross pathology and not as photographic reproductions of specific disease; and furthermore, these changes cannot stand alone, but must be interpreted in the light of the clinical observations. If the specific etiologic diagnosis still eludes the investigator, special procedures such as bronchoscopy or even exploratory surgery may be indicated, or he may prefer to keep the patient under constant and close surveillance in the hope that some helpful information may present itself as a result of the progress of the morbid condition.

By following such a plan the physician will not only revert once again to the status of a clinician who is concerned with a human being suffering the effects of a morbid process, but he will likewise have the satisfaction of knowing that he has pursued the problem in an orderly and scientific manner with the greatest likelihood of an early and correct solution.

The following brief reports of cases are examples of common errors in diagnosis which result when undue reliance is placed on the roentgenologic aspects to the neglect of the other branches of the pulmonary investigation.

Report of Cases

Case 1.—C. M., a woman aged 45, had been complaining of cough, wheezy respiration, expectoration and subfebrile temperature for several months. On the basis of the roentgenogram (fig. 1), which revealed a cavity of the upper lobe of the right lung, the patient was treated for tuberculosis. More complete studies with bronchoscopic examination and culture of the aspirated secretions disclosed that this was a case of bronchopulmonary aspergillosis.

Case 2.—F. M., a man aged 48, suffered with hoarseness and harsh nonproductive cough. The roentgenogram (fig. 2) was reported as giving evidence of an aneurysm of the aorta. Continued clinical observation pointed to the diagnosis of Hodgkin's disease. High voltage roentgen therapy resulted in disappearance of the mediastinal enlargement (fig. 3).

Case 3.—E. P., a woman aged 21, who was working as a secretary, was troubled with a nonproductive cough. A roentgenogram (fig. 4) revealed a mediastinal mass which was reported as lymphosarcoma. A series of high voltage roentgen ray treatments was followed several weeks later by an aggravation of the clinical condition. Fever and a productive cough resulted, with the sputum containing many acid-fast bacilli. A roentgenogram at this time (fig. 5) revealed a bilateral destructive and exudative process through the lung fields. The original mediastinal density was doubtless a conglomeration of tuberculous lymph nodes which had caseated and ruptured through the bronchial airways. More careful attention to clinical details would have disclosed a strong family history of tuberculosis, and a high degree of tuberculin sensitivity which might have suggested the correct diagnosis.



Fig. 1—Case 1

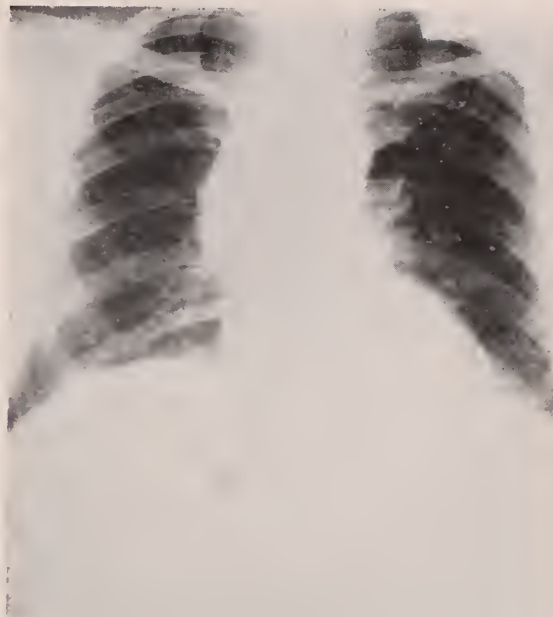


Fig. 2—Case 2



Fig. 3—Case 2

Case 4.—A. R., a man aged 72, had a severe cough and profuse expectoration, and appeared extremely emaciated. The destructive process of the upper lobe of the left lung (fig. 6) was interpreted as pulmonary tuberculosis of advanced degree, and the patient's family was instructed to have him immediately removed from the general hospital. The hospital was induced to permit the patient to stay till the examinations were completed. These revealed consistent absence of acid-fast bacilli in the sputum despite eight to twelve ounces of purulent expectoration daily. The patient died three weeks later, and postmortem examination revealed a nonputrid pulmonary abscess.

Case 5.—C. K., a woman aged 38, was troubled with a moderate cough and a slight amount of expectoration. The roentgenogram (fig. 7) was interpreted as indicating an old inactive minimal process, on the basis of the dense area at the right costophrenic angle and the minimal changes in the upper lobe of the right lung. Further clinical study revealed, however, that the sputum was consistently positive for acid-fast bacilli and that three children were highly tuberculin-sensitive.



Fig. 4—Case 3



Fig. 5—Case 3



Fig. 6—Case 4



Fig. 7—Case 5

Case 6.—D. C., a man aged 63, complained of pain over the left side of the chest anteriorly. A roentgenogram (fig. 8) was interpreted as giving evidence of pleural thickening at the left cardiophrenic angle. Despite persistence of his complaint he was reassured that there was no serious condition present on the basis of the roentgen report. When he was finally restudied eight months later, a large effusion (fig. 9) was discovered in the left pleural space. Further studies disclosed a bronchiogenic carcinoma at the left lower lobe bronchus. He was then deemed inoperable.

Case 7.—W. F., a man aged 48, was suffering with cough and weakness, and had lost 20 pounds in weight during the preceding four months. The roentgenogram (fig. 10) was reported as giving evidence of a bronchiogenic carcinoma of the upper lobe of the right lung. The patient was subjected to excisional surgery in view of the persistence of the pulmonary pathology. Section of the removed portion of lung revealed the presence of unresolved pneumonic inflammatory disease. There was no evidence of malignant disease.



Fig. 10—Case 7

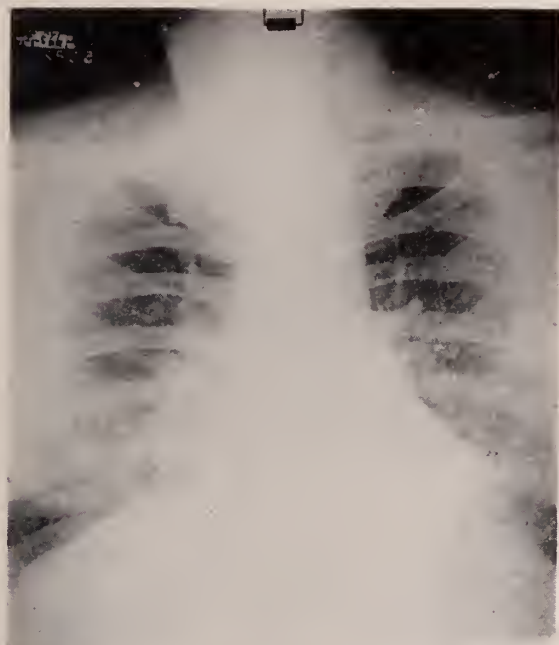


Fig. 8—Case 6



Fig. 9—Case 6



Fig. 11—Case 8

Case 8.—N. N., a man aged 50, complained of severe pain over the right shoulder girdle. Investigation at several hospitals and private physicians' offices over a period of a year yielded the diagnosis of thickening of the right apical pleura as revealed by the roentgenogram (fig. 11). After persistent demands on the part of the patient that something be done to relieve the extreme pain for which morphine was not too effective, he was subjected to pulmonary surgery. Section of the removed upper lobe of the right lung revealed the presence of carcinoma.

Case 9.—M. T., a woman aged 19, complained of cough, fever and expectoration one week following removal of infected tonsils under general anesthesia. On the basis of the density of the upper lobe of the right lung (fig. 12), a diagnosis of aspiration pneumonia was made. The patient continued to go downhill with dissemination of the process through both lung fields. Later examination of the sputum revealed persistent presence of acid-fast bacilli.



Fig. 12—Case 9

Case 10.—M. C., a woman aged 20, complained of cough, fever and expectoration of a week's duration. The roentgenogram (fig. 13) was reported as indicative of pneumonia of the upper lobe of the left lung. Three weeks later the density was still present, and the symptoms more pronounced. Shortly thereafter the expectoration became foul. With elicitation of the information that the patient was an epileptic and had had a grand mal seizure a week prior to the onset of the present illness, the diagnosis of a putrid abscess of the lung was established. The disclosure of these facts earlier would have accelerated the diagnosis.

Although these are only a sprinkling of the many instances of improper and delayed diagnosis encountered in any chest specialist's practice, they illustrate graphically the insecurity of a diagnosis which is based primarily on roentgenologic grounds.

Conclusion

It is apparent to those interested in diagnoses of diseases of the chest that both delay and errors in diagnosis occur with sufficient frequency to be embarrassing to the physician and most harmful to the patient. The source of these delays and

errors, paradoxical as it may seem, is, in many instances, the instrument that is usually relied upon most heavily in this branch of medicine, the x-ray. The undue emphasis placed on this modality to the neglect of other important means of investigation, and the practice of accepting the x-ray image as the photographic representation of specific disease, are the two main reasons for the abuse of this important instrument in pulmonary diagnosis. If the problem were viewed as a clinical manifestation for the solution of which all the branches of clinical investigation are necessary, each receiving its proper and careful consideration, the actual value of the roentgen examination would be enhanced, its service for good augmented, and the likelihood of error greatly reduced.

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Fig. 13—Case 10

Tick Paralysis: Report of a Case from Florida

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PENSACOLA

Tick paralysis is a condition which has been recognized since 1824 when it was first described in Australia. The earliest human cases in the United States were reported in 1912 by Temple.¹ Since then numerous cases have been reported in the Rocky Mountain states, which were carefully summarized by Abbott² in 1943. These cases have almost universally been caused by the tick *Dermacentor andersoni* Stiles, which also causes such diseases as Rocky Mountain spotted fever, tick fever, American Q fever and tularemia. This species of tick is rare, if not unknown, in the Eastern United States. Consequently, it was not until 1938 that tick paralysis in humans was reported in this section of the country. Since then 18 cases have been reported in this area with 7 cases from Georgia, 3 from South Carolina, 3 from Virginia, 2 from Kentucky and 1 each from North Carolina, New York and the District of Columbia. These cases were well summarized by McCue, Stone and Sutton³ in 1948 and Ransmeier⁴ in 1949, and all were thought to be due to the tick species *Dermacentor variabilis* Say.

Until the present time, so far as we know, there has been no report of a case in a human being in any section of Florida. For this reason we present a case to direct attention to this apparently increasing menace in the Southeastern United States.

Report of a Case

E. W., a 4 year old white girl was admitted to Escambia General Hospital on June 13, 1949, with a referral diagnosis of bulbar poliomyelitis. The chief complaint was weakness of muscles and difficulty in swallowing. She had been well until June 12, at which time the family noted some ataxia as evidenced by more frequent falling. She was not ill, however, had no fever, and there was no headaches. She retired normally, but about 3 a.m. on June 13 she was found on the floor where she had fallen on trying to go to the toilet. During the day rapidly ascending weakness developed, and she began to have difficulty with deglutition. She was then referred to us.

Examination on admission showed a well developed and nourished child about the stated age who was accumulating saliva in the pharynx and could not speak or close her eyes. The temperature was 99.6 F. rectally. All muscles of the lower extremities, abdomen, back, upper extremities and neck were so flaccidly weak as to approach com-

plete paralysis. Deep reflexes were almost completely wiped out. There was, however, no nuchal rigidity or back sign, the Babinski sign was negative, and there was no apparent sensory change. Lumbar puncture on June 14 revealed a clear fluid under normal pressure. Laboratory data showed a normal blood picture and normal urine; spinal fluid findings were 4 cells per cubic centimeter, negative reaction to the Pandy test, and sugar 74 mg. per hundred cubic centimeters. Another spinal fluid test on June 15 gave negative results also.

The course in the hospital was stormy for the first twenty-four hours, during which time constant administration of oxygen, frequent suctioning of mucus, and feeding by parenteral routes were necessary. Then the patient began to show some slow return of strength and by June 15 she was able to swallow fairly well, but still had little peripheral muscular strength. On a basis of the findings, search was made for a tick but unsuccessfully until noon on June 16 when the nurse finally found an engorged tick on the right occipitoparietal area of the scalp. She immediately picked the tick off, and this act required some pressure. Within three hours the patient was again in a state of extreme weakness including speech and deglutition. This continued for about six more hours, following which she made rapid improvement. Twenty-four hours after removal of the tick, she was able to sit up in bed and feed herself, and twenty-four hours thereafter walked out of the hospital with only slight ataxia. When seen in the office one week later, she was free of ataxia and all reflexes were normal. The tick causing the paralysis in this case was the female *Dermacentor variabilis* Say.

This case well illustrates the salient features of this condition and its differentiation from poliomyelitis. The patient was a child, and tick paralysis occurs almost universally in childhood. The early ataxia without sensory changes, the lack of fever, absence of "spine sign" and muscular soreness, normal spinal fluid findings, and rapid recovery following removal of the tick all go to rule out poliomyelitis.

An interesting feature of this case was the dramatic worsening of the patient's condition on removal of the tick by a method causing pressure on the tick. This substantiates the impression that the paralysis is not due to infection, but rather to some neurotoxic substance excreted by the tick in some as yet unknown manner. It also illustrates the importance of proper removal by surgical excision, chloroform or ethyl chloride anesthesia of the tick, or by use of heat such as given off from

a lighted cigaret to avoid compressing neurotoxic substance into the host.

The occurrence of this case makes it imperative that physicians in Florida keep this diagnosis in mind when they encounter any unusual afebrile ataxias, weaknesses and poliomyelitis-like illnesses. Certainly the vector, the *Dermacentor variabilis* Say, is a common insect in all areas of the state.

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24 W. Chase St.

ABSTRACTS OF MEDICAL ARTICLES

THE PRACTICAL VALUE OF LIVER FUNCTION TESTS IN CLINICAL MEDICINE. By Donald F. Marion, M.D., and John M. Rumball, M.D. *South M. J.* 41:601-614 (July) 1948.

The purpose of this report is to emphasize the practical usefulness of frequent progress studies employing a group of well proved liver function tests and also to direct attention to the difficulties encountered by the clinician who wishes to follow his patients in this manner when he must work in a community with inadequate hospital and laboratory facilities. The six tests used in a series of 66 cases are recommended as particularly useful, both for assistance in differential diagnosis and for the follow-up studies which greatly aid in the evaluation of treatment and give valuable prognostic information.

Four disease groups represented in the series were typical infectious hepatitis, chronic hepatitis, cirrhosis and extrahepatic obstruction. The majority of the jaundiced patients were followed by repeated estimations of the icteric index with the usual potassium dichromate standard of Meulengracht. The cephalin cholesterol flocculation tests were performed in the manner originally described by Hanger, with all serums and serum emulsions carefully protected against the influence of light as recommended by Neeffe and Reinhold. MacLagen's method was followed in carrying out the thymol turbidity tests. Serum phosphatase was determined by the procedure described by Bodansky, and the urinary urobilinogen studies were made upon single midafternoon specimens using

the Wallace and Diamond technic. The five milligram per kilogram bromsulfalein retention tests were done in the manner described by Mateer and his associates, using the 45-minute end point for normal total clearance.

Charts graphically portray the typical behavior of each test as it was applied to individual cases throughout periods of hospitalization averaging fifty days. To supplement the statistical material, 4 representative cases are reported.



CONGENITAL EYE MUSCLE ANOMALIES (RETRACTION SYNDROME AND CONVERGENCE INSUFFICIENCY). By George M. Haik, M.D., Louis A. Breffeilh, M.D., and Ned W. Holland, M.D. *New Orleans M. & S. J.* 101:392-395 (Feb.) 1949.

Dividing the causes of squint or strabismus into (1) deformities of the extraocular muscles, (2) deformities of innervation of the extraocular muscles and (3) errors of refraction, the authors discuss the defects in the muscles which are congenital in origin. As an aid to diagnosis, they present 2 cases which illustrate the congenital defects most commonly observed. The first is a case of Duane's syndrome or the retraction syndrome, and the second a case of convergence insufficiency. In both, the anomaly had been present since birth.

They observe that the diagnosis of strabismus can be made with the minimum of equipment and that treatment may be satisfactorily carried out. It is their conclusion that a proper diagnosis is essential to satisfactory results and only by the scientific approach may progress be made in the surgical correction of motor muscle anomalies.

DEMONSTRATION OF SINUS TRACTS, FISTULAS, AND INFECTED CAVITIES BY LIPIODOL. By Major James M. Dell, Jr. *Am. J. Roentgenol.* 61:223-231 (Feb.) 1949.

The purpose of this paper is to present the technic of the injection of sinus tracts, fistulas and infected cavities. The justification is the scarcity of literature on this subject, the fact that by the information gained curative procedures are instituted at an earlier date, and that the surgeon explores with preoperative knowledge of the extent and direction of the disease process.

The chief observations of the author follow: Many uninfected defects in bone as the result of penetrating metal show a surrounding zone of sclerosis. Many other cases have foreign bodies in the soft tissues and bone. The continued drainage may be due either to the foreign body or to the cavity in bone. Lipiodol will usually determine which or both. There are many infected cavities in bone which have an internal connection with the bowel. It is probably always correct to repair the fistula first.

Cavities near or in joints probably require treatment in patients who are to be treated later by arthroplasty. It seems that the optimum time for operative intervention is as soon as the bone is strong enough to prevent fracture. The longer a cavity remains with infection, inadequate drainage, or foreign bodies the more fibrosis and the less likelihood of closure. At times the tract leading to the focus is very long and passes near important structures or organs. In many cases of this type it would not be advisable to follow the tract in operating. Lipiodol injection in determining the location of the focus allows a planned and more effective operative approach.

Excellent illustrations accompany the article.

HEMATOMAS OF THE PARTURIENT CANAL. By John P. Michaels, M.D., and John S. Herring, M.D. *South. Surgeon* 14:583-594 (Aug.) 1948.

Hematomas occurring during or after delivery, while infrequent, are sometimes a grave complication of pregnancy and, for the most part, are preventable. The authors present 17 cases, bringing the total number of reported cases to 199. In this series the mortality rate was 17.7 per cent. They observe that careless repair of episiotomies and tears, and unrecognized tears of the vulva and vagina are extremely significant in the etiology of these hematomas, that the frequent occurrence of this tumor in the patient with toxemia is borne

out by an incidence of 53 per cent in this series, that the clinical picture is variable, that an early diagnosis is essential particularly in the suprapelvic variety and that severe pain is a significant feature in the majority of cases.

Treatment begins with prophylaxis, which consists in avoiding forceful and hurried delivery whenever possible. Difficult delivery should be followed by careful inspection of the vulva and vagina for tears, which should be promptly and carefully repaired. Closure of the upper angle of the episiotomy is imperative. When toxemia with a tendency to increased bleeding is present, calcium and vitamin K are indicated.

Small vulvar or vaginal hematomas may be treated expectantly with pressure, ice bags, and careful surveillance. Larger hematomas require prompt incision, drainage, and ligation of bleeding vessels. The application of hemostatic agents such as gelfoam, fibrin foam, or oxycel should help materially. Packing of the hematoma cavity and vagina is indicated along with transfusions, antibiotics and sulfa drugs. In addition, where the hematoma has extended subperitoneally, laparotomy to secure hemostasis is usually indicated.

VASCULAR TUMORS OF THE BRAIN AND SPINAL CORD AND THEIR TREATMENT. By Mason Trupp, M.D., and Ernest Sachs, M.D. *J. Neurosurg.* 5:354-371 (July) 1948.

The neurosurgical diagnosis and treatment of vascular tumors of the brain and spinal cord were initiated in 1915 by Dr. Ernest Sachs, who contributed a paper on "Intracranial Telangiectasis: Symptomatology and Treatment, with Report of Two Cases," which appeared in the *American Journal of Medical Sciences*. The accumulated data of thirty-three years of additional experiences by Trupp and Sachs are detailed in the report of a series of 28 cases, 7 of which occurred in the spinal cord and 21 in the cerebral or cerebellar cortex. The hemangioblastomas, true neoplasms, are not included in this series. Most vascular tumors are not arteriovenous neoplasms, but remnants of fetal tissue displaced or disordered in development. There are imperceptible gradations ranging from telangiectases to venous and arterial angiomas in which one of, or mixtures of, the other types predominate, making it impossible to diagnose them precisely as angioma venosum or angioma arteriale, as suggested by Cushing and Bailey. From practical considerations from a clinical point of view, whether of treatment or prognosis, it is entirely

adequate to call these lesions either telangiectases or angiomas.

Diagnosis of these lesions prior to operation is often difficult to make. Occasionally the diagnosis may be made from the roentgenogram, in which some of the larger vessels are calcified, but often, in addition to the larger vessels seen in the roentgenogram, there may be a mass of capillary vessels not depicted roentgenologically. When in a patient with a large skin telangiectasis there develops a paraplegia, with a level corresponding to the site of the lesion, the diagnosis is obvious. In the cranial cases, history of prolonged Jacksonian convulsions, without pressure symptoms and without history of trauma, should make one suspect such a lesion. If, in addition, there are lesions in the skin, this diagnosis becomes more likely. If there is a vascular abnormality of the retina, an intracranial blood vessel lesion is often probable. In 1930, Dr. Sachs pointed out that, since in certain cases of polycythemia choked disks had occurred, the possibility that a tumor might be present should be considered in every instance, and the removal of a cerebellum angioma resulted in a normal blood. Whether eyeground changes that are indistinguishable from choked disks may occur in polycythemia and yet not be associated with tumor is still an unsettled question.

Vascular tumors of the spinal cord presented the picture of a focal spinal lesion, which might be produced by any tumor. The cranial cases, on the other hand, have focal signs, but the one sign most striking was the absence of choked disks. Often the vessels are so thin that ligation as a method of treatment is particularly precarious, because the sutures tear through. Silver clips were found to be useless because they are too small to encompass many of the larger vessels.

In 1929, Dr. Sachs described a new method of applying electrocoagulation in the treatment of these vascular tumors; by using especially low coagulating current and stroking along the vessel wall, it is possible gradually to shrink the unusually large vessels and then, finally, to obliterate them. The procedure must be carried out slowly, a low current must be used, and the vessel must be stroked backward and then forward, but never grasped. This latter precaution is essential, for if a vessel is grasped and coagulated, the tissue will stick to the forceps, which, when removed, may tear the vessel. Success with this method since 1929 has prompted the use of electrocoagulation on these tumors whenever possible.

Using electrocoagulation as described is not a dangerous procedure. Excision of the entire lesion, as Pilcher described in 3 cases, would not have been applicable to most of the lesions recorded in this paper since such a radical procedure would definitely compromise essential blood supply to vital neural tissue. Only in rare instances has it been ineffective to use electrocoagulation, but in those cases in which the vessels were so friable, no other form of surgical treatment would have been applicable, and in some of the cases operation was followed with deep roentgen therapy as in the routine procedure after excision of hemangioblastomas. In 1 case it was thought that an excessive amount of roentgen therapy might have been a factor in the patient's ultimate death, eleven years after she was first seen. The skull showed great necrosis, which might have been the late result of prolonged roentgen therapy. The article is illustrated by nine half tone drawings.



INCOMPLETE DIVISION OF THE ATRIOVENTRICULAR CANAL WITH PATENT INTERATRIAL FORAMEN PRIMUM (PERSISTENT COMMON ATRIOVENTRICULAR OSTIUM). By H. Milton Rogers, M.D., and Jesse E. Edwards, M.D. *Am. Heart J.* 36:28-54 (July) 1948.

Five cases of congenital cardiac disease termed incomplete division of the atrioventricular canal with patent interatrial foramen primum (persistent common atrioventricular ostium) are reported, and the essential pathologic and clinical features of an additional 50 cases reported in the literature are reviewed. In the series of 55 cases, the median age of the patients at the time of death was 10 months; more than half died before attaining 1 year of age, and only 5 lived beyond the age of 30 years. There was no predilection for either sex.

The lesion characterizing this anomaly acts as does a simple interatrial septal defect. Commonly associated secondary lesions are enlargement of the right side of the heart and widening of the pulmonary artery orifice. Cyanosis, usually acquired but occasionally present at birth, is a sign of failure of the right side of the heart, pulmonary disease, or both. Cardiac murmurs, usually systolic, are frequently observed. Mongolism is a relatively common associated finding. Bacterial endocarditis occurs occasionally, having been observed in 3 of the 55 cases of the series.

SOMATIC PAIN DUE TO FIBROLIPOMATOUS NODULES, SIMULATING URETERO-RENAL DISEASE: A PRELIMINARY REPORT. By Louis M. Orr and (by invitation) Fred Mathers, and Thomas C. Butt. *J. Urol.* 59:1061-1069 (June) 1948.

These authors located nodules in the body dermatomes of the twelfth dorsal and first and second lumbar vertebrae which, on clinical investigation, proved to be a somatic cause for pain simulating ureteral and renal disease, after a careful search of the urinary tract had revealed no evidence of disease. Because of the histologic structure of the nodules, they elected to describe them as "fibrolipomatous." Nerve fibers not previously described were also demonstrated in the nodules. Usually easily palpable except in the particularly obese patient, the nodules are painful to pressure, and often pressure will reproduce distant referred pain. Under local anesthesia pinching of the exposed nodule will cause radiation of pain to the ureter, kidney or testicle, depending upon the segmental location of the nodule.

It is suggested that in all patients who experience pain simulating ureterorenal disease in the absence of evidence of urologic disease to account for the pain, a careful examination of the back may reveal a somatic cause in the form of a fibrolipomatous nodule. Five illustrative cases are reported, in which removal of the nodules completely relieved the pain.

MULTIPLE ARTERIAL EMBOLI; THREE SUCCESSFUL EMBOLECTOMIES IN A CASE OF BACTERIAL ENDOCARDITIS. By H. William Scott, Jr., M. D., and J. Maxwell Williams, Jr., M.D. *Arch. Surg.* 58:28-34 (Jan.) 1949.

A case is reported which illustrates the value of prompt embolectomy in three successive episodes of arterial embolism occurring in a young man with bacterial endocarditis. It also stresses the desirability of close cooperation between medical and surgical services in utilizing this plan of treatment.

The authors regard arterial embolism as a true surgical emergency and state that a markedly diminished cardiac-reserve should not be a deterrent to arterial embolectomy, with local or regional anesthesia. They concur in the opinion of other writers that the optimal treatment of peripheral arterial emboli involving the lower extremities is prompt embolectomy, with local anesthesia, supplemented by lumbar sympathetic block and use of papaverine and anticoagulants. In their case,

however, lumbar sympathetic block was not performed before the second embolectomy because a spinal anesthetic, accomplishing the same purpose, was given almost immediately. It is noteworthy that during the second and third embolectomies no excessive bleeding was encountered, despite the fact that the patient was fully dicumarolized. All wounds healed by first intention without hematoma or ecchymosis.

Noting that major embolic phenomena occurring during the course of bacterial endocarditis are usually visceral, the authors observe that large peripheral emboli occluding the major vessels of the extremities apparently have been uncommon. They suggest that cases of this type may be more frequently encountered in future as several observers have noted an increased incidence of embolism since the advent of intensive penicillin therapy of this disease.

CARCINOMA OF THE URETER: REPORT OF THREE CASES. By W. H. Brooks. *J. Urol.* 61:29-35 (Jan.) 1949.

In view of the relative rarity of primary tumors of the ureter, 3 cases are reported in which carcinoma was primary in this location. In case 1, a diagnosis of impacted calculus in and perforation of the lower portion of the right ureter was made. At operation, because of a rupture in the ureter 2 inches above the ureterovesical junction and an impacted calculus at this junction which could not be removed because of the inflammatory and friable condition of the ureter, ureterocutaneous anastomosis was performed. Greatly depressed over the ureterostomy, the patient elected nephrectomy, and twelve days after the first operation, nephroureterectomy was accomplished in one stage. On pathologic examination, papillary carcinoma of the upper segment of the ureter was discovered. For six years postoperatively there had been no evidence of recurrence.

In cases 2 and 3, tumor of the left ureter was diagnosed preoperatively. In the former, nephrectomy and partial ureterectomy were performed, and the pathologic diagnosis was scirrhous carcinoma of the wall of the ureter. In the latter, nephroureterectomy was performed, and the pathologic diagnosis was papillary carcinoma of the ureter with squamous metaplasia, early sclerotic changes in the kidney and abscess of the kidney.

INSULIN SUB-SHOCK IN THE TREATMENT OF ANXIETY STATES. By Sullivan G. Bedell, M.D. South. M. J. 42:130-132 (Feb.) 1949.

A series of 30 cases of psychoneurosis treated in private practice with subshock doses of insulin and psychotherapeutic interviews is reported. In all cases hospitalization had become necessary, and in general the cases were of severe psychoneurosis, more or less chronic, with manifold physical symptoms of a functional nature, various phobias, perhaps a trace of depression, a great deal of tension, and anxiety a prominent feature. The duration of the illness ranged from one month to thirteen years. The majority of the patients had been ill from one to two years. Seven were men, and 23 were women. Their ages ranged from 19 to 54 years. The duration of the course of treatment ranged from one to eight weeks with an average of three and one-half weeks per patient.

The method of treatment is described, and it is pointed out that in psychoneuroses in which anxiety is a prominent feature functional physical symptoms are especially distressing. Indeed, a vicious cycle is usually present. The physical

symptoms, which always seem to involve an imbalance of the autonomic system, with headache, choking sensations, tachycardia and pylorospasm, are so distressing as to produce ever increasing anxiety which in turn produces ever increasing physical symptoms. Thus the illness is prolonged and intensified beyond any logical reaction to psychic and situational factors. The insulin in subshock doses appears to relieve tension and to facilitate autonomic balance. With the subsidence of the distressing physical symptoms and return of a feeling of relaxation and well being, the patient is much more amenable to psychotherapy and situational difficulties can be more readily solved or accepted. Insulin subshock, therefore, has proved an invaluable aid in the treatment of severe psychoneurosis in which anxiety is a prominent feature. After at least six months' follow-up of this series, 1 patient is unimproved, 1 has relapsed, 3 improved markedly but have been lost to follow-up, 1 continues to improve slowly, and 24 are greatly improved or apparently recovered.



A superb stretch of private ocean beach for bathing and sun-lazing.



Spacious, luxurious Hollywood Beach Hotel, Convention Headquarters for 1950 at Hollywood-by-the-Sea.

Hollywood-by-the-Sea

THE CONVENTION CITY

For the third time in seventeen years the delightful city of Hollywood with its friendly people and beautiful homes will this year welcome the Florida Medical Association for its annual convention. Located on Florida's lower east coast, only eighteen miles north of Miami, this rapidly growing community is a well known and popular resort. With the Gulf Stream at its door, it boasts a climate unexcelled anywhere in the nation and presents statistics on temperature to bolster its slogan, "Cool in summer and warm in winter."

An important part of the Greater Miami area, Hollywood was founded in 1921 and incorporated in 1925. It has had a colorful history, surviving hurricane and depression to become in the last ten years one of the fastest growing cities in the United States.

The Hollywood Beach Hotel, where the convention will be held, is a major attraction of Hollywood and truly a city within itself. Ranking among the nation's finest resort hotels, it is entirely adequate to house the entire convention. Its oceanfront setting and famous hospitality are familiar to many members, for the Association

first met there in 1933. Again in 1942, under emergency circumstances the annual meeting was held there, and the many gracious courtesies extended on short notice by the management and staff continue to be remembered and appreciated.

The hotel offers unexcelled recreational facilities. The Atlantic Ocean and the private bathing beach with the usual beach sports beckon, while the golf course nearby, owned and operated by the hotel, has its peculiar appeal. There is also the Orange Brook Golf Club, which is municipally owned. Fishermen will find their angling requirements well provided for, whether they prefer the Gulf Stream, the Florida Keys or near at hand fishing grounds.

The Hollywood Beach Hotel, the city of Hollywood and the surrounding famed resort area afford exceptional and innumerable opportunities for diversion and entertainment that should have wide appeal to the members and their families throughout the state. These features, the excellent scientific program and the many attractive technical exhibits give promise that the seventy-sixth session of the Association will be outstanding in attendance, in interest and in benefit.

PROGRAM

of the

Seventy-Sixth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

To be Held at HOLLYWOOD

APRIL 24, 25 and 26, 1950

REGISTRATION

East End of Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the above designated Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay \$3.00 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Patio near the pool at 9:00 p.m. Monday and worn throughout the evening.

CONVENTION HEADQUARTERS

HOLLYWOOD BEACH HOTEL

The general headquarters will be the Hollywood Beach Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical exhibit hall will be located.

The Hollywood Beach Hotel will be headquarters Saturday and Sunday for the 18 specialty groups approved by the Board of Governors.

HOTELS

HOLLYWOOD BEACH—HOTEL HEADQUARTERS
(*American Plan*)

Single \$14.00 Double \$28.00

American Plan rates at the Hollywood Beach Hotel include meals, which are priced as follows:

Breakfast \$1.50
Luncheon 3.00
Dinner 5.00

Persons not lodging at the headquarters hotel may be served meals in the Main Dining Room at the prices quoted.

For your convenience we have arranged with the hotel management that there shall be no tipping at any meal. A charge of \$1.00 per day will be posted to your hotel account to provide gratuities for dining room employees. Individual meal tickets sold at cashier's window will have 10% added to cover gratuities for those who do not have rooms in the Headquarters Hotel.

OTHER HOTEL ROOMS

SHELDON
(100 Boardwalk)

Single Rooms	\$ 5.00
Double Rooms	\$ 7.00

GREAT SOUTHERN
(Hollywood Blvd.)

Single Rooms	\$ 3.00
Double Rooms	\$ 4.00

HUTCHINSON
(404 N. 17th Ave.)

Double Rooms	\$ 4.00
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JOHNSON HOUSE
(998 S. Federal)

Single Rooms	\$ 4.00- 5.00
Double Rooms	\$ 5.00- 6.00

SEASIDE MANOR
(Ocean Dr.—Mich. St.)

Single Rooms	\$ 4.00
Double Rooms	\$ 5.00

WINDSOR
(322 Buchanan St.)

Single Rooms	\$ 3.00
Double Rooms	\$ 4.00- 8.00

TRIANON
(1957 Monroe St.)

Single Rooms	\$ 3.00- 4.00
Double Rooms	\$ 4.00- 6.00

CARR GUEST HOUSE
(1539 Harrison St.)

Single Rooms	\$ 3.50
Double Rooms	\$ 5.00

ROSE MARIE
(1934 Van Buren)

Single Rooms	\$ 2.50
Double Rooms	\$ 3.00

SURF
(300 Boardwalk)

Single Rooms	\$ 7.50
Double Rooms	\$13.00

MOTELS

FLAMINGO
(1419 S. Federal)

Single Rooms	\$ 3.00
Double Rooms	\$ 5.00

FILSON
(1753 Jackson St.)

Single Rooms	\$ 4.00
Double Rooms	\$ 5.00

EL RANCHO HOTEL COURT
(1 Mile S. of Circle)

Rooms (2-4 guests) \$ 7.00 up
One bedroom apartments (weekly) \$50.00

DILLOWS
(1831 Plunket St.)

Single Rooms \$ 3.50
Double Rooms \$ 4.00
One bedroom apartments (weekly) \$35.00-40.00

NEPTUNE APARTMENTS

(2012 N. Surf Rd.)

Efficiency Apartments (weekly) \$35.00

GOLF

The annual handicap golf tournament for members of the Florida Medical Association will be played at the Hollywood Beach Hotel Links. The tournament will be held Sunday, Monday and Tuesday, April 23, 24 and 25. There will be no Green Fees for members registered at the Hollywood Beach Hotel. Those registered elsewhere will be charged \$1.00 per day. Transportation and lockers will be on a free basis.

Those wishing to participate must be registered and show F. M. A. badges.

Rules: U. S. Golf Association, except local rules.

Handicaps: The local professional will handicap the players. The entrant must register with the starter before beginning his tournament round.

Score card must be dated, signed, attested and turned in to the starter at the end of the round.

Voucher for prizes will be awarded at the Association dinner. First prize: Orlando Loving Cup (low net score). Many other attractive prizes will be awarded. (*The last winner of the Orlando Loving Cup, Dr. Dodge D. Mentzer of Lakeland, is requested to deliver the cup to Dr. Curtis D. Benton, Jr., chairman of the local committee, on his arrival at the convention.*)

For additional information contact Dr. Curtis D. Benton, Jr., Sweet Building, Ft. Lauderdale, telephone 2 1343.

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

- 1931—M. A. Lischkoff, Pensacola
- 1932—Clarence A. Rudisill, Tampa
- 1933—Blackburn W. Lowry, Tampa
- 1934—Heyward J. Blackmon, Tampa
- 1935—M. A. Lischkoff, Pensacola
- 1936—Shaler Richardson, Jacksonville
- 1937—J. R. Chandler, Daytona Beach
- 1938—William Y. Sayad, West Palm Beach
- 1939—James T. Cowart, Tampa
- 1940—Lucien B. Dickerson, Clearwater
- 1941—William C. Roberts, Panama City
- 1942—Clarence A. Rudisill, Tampa
- 1943—No tournament (war)
- 1944—No tournament (war)
- 1945—No tournament (war)
- 1946—Walter C. Jones, Miami
- 1947—Walter F. Davey, Stuart
- 1948—Robert D. Harris, Jr., St. Augustine
- 1949—Dodge D. Mentzer, Lakeland

ANGLERS

Deep sea fishing trips will be available. Boats leave from the City Pier. Arrangements can be made for all day or short trips at nominal charges.

For additional information communicate with Dr. Leroy B. Elliston, chairman of the Anglers Committee, Blount Building, Ft. Lauderdale.

TRAPSHOOTERS

Members interested in trapshooting should communicate with Dr. Edward A. Abbey, chairman of the Trapshooting Committee, 370 S. E. 2nd St., Ft. Lauderdale.

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

All persons wishing to attend an Alumni or Fraternity Supper are requested to notify Dr. Julius F. Boettner, local chairman, Sweet Building, Ft. Lauderdale. It will be impossible to arrange for these suppers until word is received from all those who wish to attend. Please notify Dr. Boettner well in advance of the convention and specify which group you wish to attend. Each doctor planning to attend is requested to make a reservation at the *Information Table* in the Main Lobby of the Hollywood Beach Hotel before 12:00 noon Monday.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

Those who are not lodging at the headquarters hotel may obtain dinner tickets (\$5.00 per person) from the hotel cashier.

SMOKER (*Not Stag*)

Monday, 9:00 p.m.

HOLLYWOOD BEACH HOTEL—PATIO NEAR THE POOL

The highlight of the convention will be our annual Smoker at the Patio near the pool of the Hollywood Beach Hotel. An enjoyable evening of entertainment and fun has been arranged for members, their guests and ladies by the local Smoker Committee, of which Dr. Paul G. Shell is chairman.

Smoker privileges will be \$3.00. Get your tag before 5:30 p.m. at the Registration Desk in the Exhibit Hall.

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the Great Lounge of the headquarters hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

- S 1. The Menace of the Rat. Thomas G. Hull, Ph.D., Director, Scientific Exhibit of the American Medical Association, Chicago
- S 2. Precancerous Lesions of the Skin. Wesley W. 3. Wilson, M.D., Tampa
- S 4. Cancer of Head and Neck. J. Brown Farrior, 5. M.D. and Richard A. Bagby, M.D., Tampa.
- S 6. Cancer of the Esophagus. C. Frank Chunn, M.D., Tampa.
- S 7. A series of photographs, charts, graphs, and tables showing the history, pharmacology, clinical applications and indications for the use of Aureomycin HCl, Lederle.
- S 8. Florida State Board of Health, 9. Wilson T. Sowder, M.D.
- S 10. Florida Medical Service (Blue Shield). Leigh F. Robinson, M.D., Ft. Lauderdale
- S 11. Public Relations, Florida Medical Association. Joseph S. Stewart, M.D., Miami.

TECHNICAL EXHIBITS

Technical exhibits will be located in the Great Lounge of the Hollywood Beach Hotel. The technical exhibits have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors have nothing to sell, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Hollywood meeting:

1. Eli Lilly and Company
2. The Wm. S. Merrell Company
3. Parke, Davis & Company
4. Ciba Pharmaceutical Products, Inc.
5. C. B. Fleet Company
6. U. S. Vitamin Corp.
7. Anderson Surgical Supply Company
- 8-20. General Electric X-Ray Corp.
9. Sharp & Dohme, Inc.
10. The Borden Company
11. Schering Corp.
12. McCall-Rising, Inc.
13. Byron Thompson & Company, Inc.
14. Medical Supply Company
17. Abbott Laboratories
18. Eaton Laboratories, Inc.
19. Winthrop-Stearns, Inc.
21. Picker X-Ray Corporation
22. Surgical Equipment Company
23. Parco Surgical Supplies
24. Sandoz Pharmaceuticals
26. The Upjohn Company
27. Burroughs Wellcome & Co. (U.S.A.) Inc.
28. S. H. Camp & Company
29. Endo Products, Inc.
30. Tablerock Laboratories
31. Walker Vitamin Products, Inc.
32. Keleket X-Ray of Florida
33. The National Drug Company
34. Ortho Pharmaceutical Corp.
35. Philip Morris & Co., Ltd, Inc.
36. American Optical Company
38. The Nestlé Company
- 39-40. The Coca-Cola Company
41. H. G. Fischer & Company
42. Wyeth, Inc.
43. E. R. Squibb & Sons
44. A. S. Aloe Company
45. Camel Cigarettes
46. G. D. Searle & Co.
47. Lederle Laboratories Division
48. Mead Johnson & Company
49. Pet Milk Company
50. Professional Insurance Corp.
- 51-52. Westinghouse X-Ray Division
53. M & R Dietetic Laboratories, Inc.
54. J. B. Lippincott Company
- S-12. J. A. Majors Company

**OFFICERS OF BROWARD COUNTY
MEDICAL SOCIETY**

RICHARD A. MILLS, *President*
M. AUSTIN LOVEJOY, *President-elect*
LLOYD U. LUMPKIN, *Vice President*
NORRIS M. BEASLEY, *Secretary*
JULIUS F. BOETTNER, *Treasurer*

LOCAL COMMITTEES**CABINET**

Lloyd U. Lumpkin, *Chairman*
Paul G. Shell Norris M. Beasley
Curtis D. Benton, Jr. Ernest E. Serrano
Leroy B. Elliston S. Elliott Wilson
Edward A. Abbey Julius F. Boettner
Royle B. Klinkenberg Donald H. Gahagen

SMOKER

Paul G. Shell, *Chairman*
Raymond M. Price Burns A. Dobbins, Jr.
Thomas L. Roberts, Jr. Wilks O. Hiatt, Jr.

GOLF

Curtis D. Benton, Jr., *Chairman*
Eugene C. Chamberlain Henry J. Peavy
Mark Butler Robert J. Patterson

ANGLERS

Leroy B. Elliston, *Chairman*
Francis Haberman Alva R. Taylor
Benjamin F. Hart Roland F. Fisher

TRAPSHOOTERS

Edward A. Abbey, *Chairman*
Herman L. Boese Scottie J. Wilson
Alfred E. Cronkite William D. Wells

HOTELS AND RATES

Royle B. Klinkenberg, *Chairman*
Randall W. Snow Samuel P. Nixon
Robert R. Harriss Thomas L. McKee

GREETERS

Norris M. Beasley, *Chairman*
Richard A. Mills Milton N. Camp
Russell B. Carson Albert A. Parrish

TRANSPORTATION

Ernest E. Serrano, *Chairman*
Rudolph W. Heath M. Austin Lovejoy
Walter J. Glenn, Jr. Thomas F. Huey, Jr.

LADIES' ADVISORY

S. Elliott Wilson, *Chairman*
Frederick J. Driscoll Francis D. Pierce
Claus A. Peterson Curtis H. Sory

ALUMNI AND FRATERNITY SUPPERS

Julius F. Boettner, *Chairman*
Dale T. Anstine James M. Weaver
Frederick P. Swing William A. Exum

FINANCE

Donald H. Gahagen, *Chairman*
Leigh F. Robinson Oliver C. Brown
Robert L. Elliston Robert E. Blount

MONDAY

FIRST GENERAL SESSION

Monday, 9:00 to 9:15 a.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

Call to Order, Walter C. Payne, President
Invocation, The Reverend Edward P. Downey
Address of Welcome, Richard A. Mills, President, Broward
County Medical Society
Announcements
Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Frederick K. Herpel, Chairman, West Palm Beach; James R. Boulware, Jr., Lakeland; Jere W. Annis, Lakeland; James L. Borland, Jacksonville; Carol C. Webb, Pensacola

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:15 a.m. to 12:15 p.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

- 9:15 a.m. "Cancer of the Head and Neck" (2" x 2" Slides), J. Brown Farrior, Tampa.
9:45 a.m. "Plastic Surgery" (2" x 2" Slides), George W. Robertson, Miami.
10:15 a.m. "Proctoscopic Color Movies," J. Peerman Nesselrod, Evanston, Illinois.
10:45 a.m. "Treatment of Pelvic Malignant Disease," Emil Novak, Baltimore, Maryland.
11:15 a.m. "Internal Biliary Fistulae" (3¼" x 4" Slides), Donald W. Smith, Miami, Maurice M. Greenfield, Miami and Martin G. Gould, Miami.

SECOND GENERAL SESSION

Monday, 2:00 p.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

Call to Order, Walter C. Payne, President
Gavel to First Vice President, David R. Murphey, Jr.
President's Address, Walter C. Payne
President Resumes Chair
Report of Secretary-Treasurer, Robert B. McIver, and
Managing Director, Stewart G. Thompson
Report of Editor of The Journal, Shaler Richardson
Introduction, Delegates from other state societies
New Business
Announcements
Adjournment

SECOND SCIENTIFIC ASSEMBLY

Monday, 3:30 to 5:30 p.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

- 3:30 p.m. "Differential Diagnosis of Low Back Pain" (2" x 2" Slides), Ralph Herz, Key West.
Discussion: John W. Snyder, Miami
4:00 p.m. "Cytologic Diagnosis of Malignant Disease" (2" x 2" Slides), Nelson A. Murray, Jacksonville.
4:30 p.m. "Chronic Pyuria in Infants and Children" (3¼" x 4" Slides), Meredith Campbell, New York, N. Y.
5:00 p.m. "Roentgen Examination in the Acute Condition Within the Abdomen" (3¼" x 4" Slides), Floyd K. Hurt and Bert H. Malone, Jacksonville.

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

SMOKER (Not Stag)

Monday, 9:00 p.m.

HOLLYWOOD BEACH HOTEL—PATIO NEAR THE POOL

The highlight of the convention will be our annual Smoker at the Patio near the pool of the Hollywood Beach Hotel. An enjoyable evening of entertainment and fun has been arranged for members, their guests and ladies by the Smoker Committee, of which Dr. Paul G. Shell is chairman.

Smoker privileges will be \$3.00. Get your tag before 5:30 p.m. at the Registration Desk in the Exhibit Hall.

TUESDAY

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:00 a.m.

HOLLYWOOD BEACH HOTEL—SUN ROOM

Delegates assemble at the Credentials Committee table at entrance of The Sun Room at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee,

Edward Jelks, Chairman
John D. Milton
James R. Boulware, Jr.

Delegates are to occupy seats in the section designated in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in another section of the room.

President Payne in the Chair, 9:30 a.m.

Number of eligible Delegates present. Report by Edward Jelks, Chairman, Credentials Committee

Motion to seat Delegates

Adoption of Minutes as published in June 1949 Journal
Election of one Delegate and one Alternate to A. M. A. House of Delegates for two-year terms

(A. M. A. By-Laws, Chapter I, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.")

Reference committee Personnel announced by President
Supplemental Resolutions or Committee Reports (*Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the speaker's table immediately after they are*

presented.

Reports of Committee Chairmen:

(To Reference Committee No. 1)

Scientific Work, Frederick K. Herpel
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Lloyd J. Netto
Venereal Disease Control, Roger F. Sondag
Tuberculosis and Public Health, Erasmus B. Hardee
Maternal Welfare, Lowrie W. Blake
Child Health, Egbert V. Anderson

(To Reference Committee No. 2)

Conservation of Vision, Joseph W. Taylor
Legislation and Public Policy, Eugene G. Peek
Medical Education and Hospitals, Bascom H. Palmer
Public Relations, Joseph S. Stewart
Medical Economics, Herbert W. Virgin, Jr.
State Controlled Medical Institutions, James G. Lyerly
Representatives to Industrial Council, G. Frederick Oetjen

(To Reference Committee No. 3)

Board of Governors, Walter C. Payne
Interrelationship, Henry J. Peavy
Necrology, Joseph Halton
Advisory to Woman's Auxiliary, Edward F. Shaver
Councilor Districts and Council, Russell B. Carson
New Business
Announcements
Adjournment

THIRD GENERAL SESSION

Tuesday, 11:30 a.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

Call to Order, Walter C. Payne, President
Address (By Invitation), "Prevention of Venous Thrombosis Based on New Concepts of Blood Coagulation" (3¼" x 4" Slides), Alton Ochsner, Director of the Section on General Surgery, Ochsner Clinic, New Orleans.
Adjournment

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:00 to 5:00 p.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

- 2:00 p.m. "Management of Cardiac Failure" (3¼" x 4" Slides), George F. Schmitt, Miami.
2:30 p.m. "Diagnosis in Heart Disease." Elywn Evans, Orlando.
Discussion: E. Sterling Nichol, Miami
3:00 p.m. "Medical Planning for Atomic Disaster" (3¼" x 4" Slides), Colonel W. L. Wilson, Medical Corps, U. S. Army, Washington, D. C.
3:30 p.m. "Dietary Treatment of Hypertension through Sodium Restriction" (3¼" x 4" Slides), M. Jay Flipse, M. Eugene Flipse and Otto W. Burtner, Miami.
4:00 p.m. "Subdiaphragmatic Abscess with Special Reference to its Roentgen Visualization" (3¼" x 4" Slides), Frederick H. Bowen and Arthur L. Hardie, Jr., Jacksonville.
4:30 p.m. "Medical Aspects of Blindness in Children" (2" x 2" Slides), Nathan S. Rubin, Pensacola.

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.

HOLLYWOOD BEACH HOTEL

The three reference committees will meet on Tuesday at 2:30 p.m. in The Ladies' Card Room, S. W. Porch and Men's Card Room. The names of the delegates who have been appointed by President Payne to serve on reference committees are listed below.

1. HEALTH AND EDUCATION

LADIES' CARD ROOM

Jere W. Annis, Chairman
Alvin L. Stebbins
Warren W. Quillian
David R. Murphey, Jr.
Webster Merritt

2. PUBLIC POLICY

S. W. PORCH

William M. Rowlett, Chairman
Francis H. Langley
Donald W. Smith
Bricey M. Rhodes
John E. Maines, Jr.

3. FINANCE AND ADMINISTRATION

MEN'S CARD ROOM

Walter C. Jones, Chairman
Robert B. McIver
Duncan T. McEwan
Herbert E. White
Herbert L. Bryans

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

Those who are not lodging at the headquarters hotel may obtain dinner tickets (\$5.00 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner
Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

Breakfast
Election of Chairman, Vice Chairman and Secretary

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:30 a.m.

HOLLYWOOD BEACH HOTEL—THE SUN ROOM

- 9:00 a.m. "The Diagnosis and Treatment of Diseases of the Chest, with Emphasis on the value of Consultation" (3¼" x 4" Slides), Turner Z. Cason, Jacksonville.
Discussion: Floyd K. Hurt, Jacksonville
Ashbel C. Williams, Jacksonville
- 9:30 a.m. "Infectious Hepatitis" (3¼" x 4" Slides), Henry Fuller, Lakeland.
- 10:00 a.m. "Nummular Eczema, Its Differential Diagnosis and Treatment" (2" x 2" Slides), Burton F. Barney, West Palm Beach

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:30 a.m.

HOLLYWOOD BEACH HOTEL—SUN ROOM

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Edward Jelks, Chairman, John D. Milton and James R. Boulware, Jr., located at entrance to The Sun Room. (*No Alternates are to be seated for Delegates attending yesterday's meeting*)

President Payne in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Edward Jelks, Chairman, Credentials Committee
Recommendations of Reference Committees:

No. 1. Health and Education

Jere W. Annis, Chairman

No. 2. Public Policy

William M. Rowlett, Chairman

No. 3. Finance and Administration

Walter C. Jones, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon

President-elect

First Vice President

Second Vice President

Third Vice President

Secretary-Treasurer

Editor of The Journal

Dr. Herbert E. White escorted to the Chair as new President

Presentation of Past President's Button and Certificate of Honor to Dr. Walter C. Payne by Dr. Herbert E. White, President

Adjournment

SPECIALTY GROUP MEETINGS

Saturday and Sunday, April 22-23

On July 25, 1948 the Board of Governors ruled that rooms be assigned to the various specialty group societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

SECOND ANNUAL MEETING

FLORIDA ALLERGY SOCIETY

OFFICERS

Frank C. Metzger, President Tampa
Clarence Bernstein, Vice Pres. & Pres.-elect..... Orlando
George F. Hieber, Secy.-Treas. St. Petersburg
Sunday, April 23

HOLLYWOOD BEACH HOTEL—SPORTS CENTER

- 8:00 p.m. 1. By invitation a paper by Jose M. Quintero
Fossas, Havana Cuba
2. "Allergy and the Heart," Solomon D. Klotz,
Orlando
Open Discussion

SECOND ANNUAL MEETING

FLORIDA SOCIETY OF ANESTHESIOLOGISTS

OFFICERS

Colquitt Pearson, President Miami
Ralph S. Sappenfield, President-elect Miami
Roger W. Gridley, Vice President Orlando
Harold Carron, Secy.-Treas Tampa

Sunday, April 23

HOLLYWOOD BEACH HOTEL—MEN'S CARD ROOM

- 8:00 p.m. Scientific Meeting
Business Meeting
Election of Officers

SECOND ANNUAL MEETING

FLORIDA CHAPTER

AMERICAN COLLEGE OF CHEST PHYSICIANS

OFFICERS

Earlsworth C. Brunner, President..... Miami
Howard K. Edwards, Secy.-Treas..... Miami
Nathaniel M. Levin, Program Committee Chairman Miami

Sunday, April 23

HOLLYWOOD BEACH HOTEL—SPORTS CENTER

- 9:30 a.m. Business Meeting
10:00 a.m. 1. "Psychic Factors in Diseases of the Chest,"
Arnold Anderson, St. Petersburg
2. "Review of Pneumothorax and pneumoperitoneum Cases in Southwestern States Sanitariums," John Barger, Tampa
3. "Segmental Resections in Bronchiectasis" (Motion Pictures), William O. Fowler, Orlando
4. "Review of Antibiotics in the Treatment of Diseases of the Chest," Alexander Libow, Miami Beach.
5. "The Role of the Laryngologist and Bronchoscopist in Diseases of the Respiratory Tract," (Color Motion Pictures), Nathaniel M. Levin, Miami
1:00 p.m. Lunch—Main Dining Room
2:00 p.m. Round Table Chest Conference
M. Jay Flipsc, Miami, Moderator
Panel Discussion by Invitation
X-Ray Aspects—David Kirsh, Miami
Medical Aspects—David A. Nathan, Miami Beach
Surgical Aspects—DeWitt C. Daughtry, Miami
And other members of the Florida Chapter of the American College of Chest Physicians

REGULAR MEETING OF THE FLORIDA
SOCIETY OF
DERMATOLOGY AND SYPHILOLOGY

OFFICERS

J. Frank Wilson, President..... Jacksonville
Morris Waisman, Vice President..... Tampa
Wesley W. Wilson, Secy.-Treas..... Tampa

Sunday, April 23

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

6:00 p.m. Dinner
Round Table Discussion of Cases
Business Meeting
Election of Officers

FOURTH ANNUAL MEETING
FLORIDA CHAPTER
AMERICAN ACADEMY OF GENERAL PRACTICE

OFFICERS

Walter E. Murphree, President..... Gainesville
Elmer E. Leitner, Vice President..... Jacksonville
John A. Wilhelm, Sec.-Treas..... Jacksonville

Sunday, April 23

HOLLYWOOD BEACH HOTEL—S. W. PORCH

8:00 p.m. Scientific Session
"Acute Abdomen" (by invitation), Philip Thorek, Assistant Clinical Professor, Department of Surgery, University of Illinois College of Medicine.

FIFTH ANNUAL MEETING
FLORIDA HEALTH OFFICERS' SOCIETY

OFFICERS

Frank L. Quillman, President..... Sanford
John M. McDonald, Vice President..... Jacksonville
Lorenzo L. Parks, Secy.-Treas..... Jacksonville

Sunday, April 23

HOLLYWOOD BEACH HOTEL—S. W. PORCH

2:00 p.m. Scientific Session
1. "Veterinary Public Health," James E. Scatterday, D.V.M., Jacksonville.
2. "A Demonstration Rural School Health Program," Robert G. Head, Marianna
3. "Diagnosis of Viral and Rickettsial Diseases," Morris Schaeffer, Montgomery, Alabama
4. "Recent Developments in Typhus Fever," Elsmere R. Rickard, Tampa
5. "State Aid Program in Relation to the Tumor Clinic," Wilbur C. Sumner, Jacksonville

SECOND ANNUAL MEETING
FLORIDA HEART ASSOCIATION

OFFICERS

E. Sterling Nichol, President..... Miami
Louie Limbaugh, Vice President..... Jacksonville
Jere W. Annis, Secy.-Treas..... Lakeland

Sunday, April 23

COLUMBUS HOTEL, MIAMI—MEZZANINE FLOOR

10:00 a.m. Directors Meeting

HOLLYWOOD BEACH HOTEL—LADIES' CARD ROOM

1:30 p.m. Scientific Program
1. "Paroxysmal Rapid Heart Action in a New-born," Jack O. W. Rash, Miami
2. "The Exercise Tolerance Test with Electrocardiographic Control," Charles K. Donegan, St. Petersburg
3. "Children's Cardiac Clinic: Report of 778 Patients," Milton S. Saslaw, Miami Beach

4. "Problems Met in the Use of Dicumarol in Acute Myocardial Infarction," Sidney Davidson, Lake Worth
5. "Electrocardiographic Interpretation," Francis A. Reed, Miami Beach
6. "Acute Nonspecific Benign Pericarditis," Elwyn Evans, Orlando
7. "A Critical Evaluation of Oscillometric Apparatus," Julius A. Oshlag, Miami Beach. (To be read in absentia because of Dr. Oshlag's recent untimely death.)

To be read if time permits:

"Mercurial Diuretics," George F. Schmitt, Miami

"Dietary Treatment of Hypertension Through Sodium Restriction," M. Eugene Flipse, Miami

"The Chest Leads in Electrocardiography," C. Marion Salley, Miami

Business Meeting

Dinner—Main Dining Room

8:00 p.m. Round Table Discussion—"Electrocardiographic Interpretation"

ELEVENTH ANNUAL MEETING
FLORIDA ASSOCIATION OF
INDUSTRIAL AND RAILWAY SURGEONS

OFFICERS

Vernon A. Lockwood, President..... St. Augustine
Frank D. Gray, President-elect..... Orlando
Charles Larsen, Jr., Vice President..... Lakeland
John H. Mitchell, Secy.-Treas..... Jacksonville

Sunday, April 23

HOLLYWOOD BEACH HOTEL—CHESS ROOM

5:00 p.m. President's Address
"Low Back Pain" (By invitation), Robert P. Kelly, Atlanta, Georgia, Professor of Orthopedic Surgery, Emory University, School of Medicine
Round Table Discussion
Business Meeting and Election of Officers

FOURTH ANNUAL MEETING
FLORIDA SOCIETY OF
NEUROLOGY AND PSYCHIATRY

OFFICERS

Whitman C. McConnell, President..... St. Petersburg
William D. Rogers, Vice President..... Chattahoochee
William H. McCullagh, Secy.-Treas..... Jacksonville

Sunday, April 23

HOLLYWOOD BEACH HOTEL—STOCK BROKERS ROOM

4:00 p.m. Scientific Session
1. "Transference Reaction in Private Practice," Marlin C. Moore, Jacksonville
2. "Remarks on Psychoanalytic Therapy," Roger E. Phillips, Orlando
Business Meeting and Election of Officers

THIRD ANNUAL MEETING
FLORIDA OBSTETRIC AND GYNECOLOGIC
SOCIETY

OFFICERS

Robert G. Nelson, President..... Tampa
Robert T. Spicer, President-elect..... Miami
Dorothy D. Brame, Secy.-Treas..... Orlando

Sunday, April 23

HOLLYWOOD BEACH HOTEL—SUN ROOM

10:00 a.m. Executive Committee Meeting
2:00 p.m. Business Session and Election of Officers
Round Table Discussion, Emil Novak, Baltimore, Md., leader
7:00 p.m. Dinner—Main Dining Room
CHESS ROOM
8:00 p.m. Scientific Session,
Emil Novak, Baltimore, Md., guest speaker

ELEVENTH ANNUAL MEETING
FLORIDA SOCIETY OF
OPHTHALMOLOGY AND OTOLARYNGOLOGY

OFFICERS

W. Jerome Knauer, President..... Jacksonville
R. Renfro Duke, Vice President..... Tampa
Charles C. Grace, Secy.-Treas..... St. Augustine

Sunday, April 23

HOLLYWOOD BEACH HOTEL—THEATRE

2:00 p.m. Scientific Session

1. President's Address of Welcome, W. Jerome Knauer, Jacksonville
2. "Bilateral Granuloma of the Larynx Following Intratracheal Anesthesia," Merrill Wattles, Orlando

Discussion: G. Dekle Taylor, Jacksonville
J. Brown Farrior, Tampa

3. "Pediatric Problems in Ophthalmology," Kenneth S. Whitmer, Miami

Discussion: Carl S. McLemore, Orlando
Francis C. Skilling, Miami

Business Meeting

Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director, Tampa

8:00 p.m. Scientific Session

1. "On Backing Out of a Cataract Operation," (By invitation), Daniel B. Kirby, New York
 2. "What Can be Done for the Hard of Hearing," (By invitation), Theodore E. Walsh, St. Louis, Missouri
- Election of Officers

FOURTH ANNUAL MEETING
FLORIDA **ORTHOPEDIC** SOCIETY

OFFICERS

Eugene L. Jewett, President..... Orlando
Edward W. Cullipher, Vice President..... Miami
Plumer J. Manson, Secy.-Treas..... Miami

Sunday, April 23

HOLLYWOOD BEACH HOTEL—CHESS ROOM

2:00 p.m. Business Meeting

Election of Officers

EIGHTH ANNUAL MEETING
FLORIDA **PATHOLOGICAL** SOCIETY

OFFICERS

Gretchen V. Squires, President..... Pensacola
Robert J. Poppiti, Vice President..... Miami Beach
Nelson A. Murray, Secy.-Treas..... Jacksonville

Sunday, April 23

HOLLYWOOD BEACH HOTEL—"A" DANCE STUDIO

10:00 a.m. General Business Session
Election of New Members
Election of Officers

2:00 p.m. General Session
Technical Problems

TWELFTH ANNUAL MEETING
FLORIDA STATE **PEDIATRIC** ASSOCIATION

OFFICERS

Hugh A. Carithers, President..... Jacksonville
Egbert V. Anderson, Vice President..... Pensacola
Charlotte C. Maguire, Secy.-Treas..... Orlando

Sunday, April 23

HOLLYWOOD BEACH HOTEL—MEN'S CARD ROOM

2:00 p.m. "Pre and Postoperative Care in Major Pediatric Surgery," Joseph R. Bowman, Johnson City, Tennessee

4:00 p.m. Case Presentations by members to be selected
Business Meeting

HOLLYWOOD BEACH HOTEL—SUN ROOM

(Joint Meeting with the Florida Urological Society)

8:00 p.m. "Urinary Tract Anomalies" (by invitation),
Meredith F. Campbell, New York City
"Pediatric Urology Forum," Meredith F. Campbell, New York City, Moderator

THIRD ANNUAL MEETING
FLORIDA **PROCTOLOGIC** SOCIETY

OFFICERS

Ralph F. Allen, President..... Miami
Frederick E. Farrer, Secy.-Treas..... Miami

Sunday, April 23

HOLLYWOOD BEACH HOTEL—"B" DANCE STUDIO

4:00 p.m. Business Meeting

8:00 p.m. Scientific Session

1. "Imperforate Anus: Three Case Reports," Don C. Robertson, Orlando
2. "Proctidia: Case Reports," Frederick E. Farrer, Miami
3. "Anal Infections," J. Peerman Nesselrod, Evanston, Ill., and Jay M. Garner, Evanston, Ill.

NINETEENTH ANNUAL SPRING MEETING
FLORIDA **RADIOLOGICAL** SOCIETY

OFFICERS

John A. Beals, President..... Jacksonville
Floyd K. Hurt, Vice President..... Jacksonville
John J. McGuire, Secy.-Treas..... Pensacola

Saturday, April 22

HOLLYWOOD BEACH HOTEL—THEATRE

2:00 p.m. Round Table Discussion—Diagnosis

8:00 p.m. Round Table Discussion—Therapy

Sunday, April 23

HOLLYWOOD BEACH HOTEL—THEATRE

9:00 a.m. Business Session and Election of Officers

THIRD ANNUAL MEETING
FLORIDA **UROLOGICAL** SOCIETY

OFFICERS

A. Fred Turner, Jr., President..... Orlando
Alvin L. Mills, President-elect..... St. Petersburg
Linus W. Hewit, Secy.-Treas..... Tampa

Sunday, April 23

HOLLYWOOD BEACH HOTEL—SUN ROOM

(Joint Meeting with Florida State Pediatric Association)

8:00 p.m. "Urinary Tract Anomalies" (by invitation),
Meredith F. Campbell, New York City
"Pediatric Urology Forum," Meredith F. Campbell, New York City, Moderator
Business Meeting
Election of Officers

FIFTH ANNUAL MEETING
FLORIDA **MEDICAL SERVICE CORPORATION**

OFFICERS

Leigh F. Robinson, President..... Ft. Lauderdale
Walter C. Jones, 1st Vice President..... Miami
Mother Loretta Mary, 2nd Vice President..... Tampa
Frederick J. Waas, Treasurer..... Jacksonville
John A. Beals, Asst. Treasurer..... Jacksonville
Herbert E. White, Secretary..... St. Augustine

Sunday, April 23

HOLLYWOOD BEACH HOTEL—LIBRARY

4:00 p.m. Dr. Robinson presiding

TWENTY-THIRD ANNUAL MEETING WOMAN'S AUXILIARY

LOCAL COMMITTEE CHAIRMEN

BROWARD

Mrs. Leigh F. Robinson, Chairman
Mrs. S. Elliott Wilson, Co-Chairman

Mrs. Robert L. Elliston Mrs. Claus A. Peterson
Mrs. Frank Denniston Mrs. Curtis H. Sory
Mrs. Richard A. Mills Mrs. Francis C. Haberman
Mrs. Roland F. Fisher

REGISTRATION

East End of the Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Auxiliary members and guests will be required to register and obtain their identification badges before attending any of the functions. Doctors' wives are invited to attend all activities of the Auxiliary.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay \$3.00 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Patio near the pool at 9:00 p.m. Monday and worn throughout the evening.

PROGRAM

Monday, April 24

Admission by F.M.A. Badge Only

- 9:30 a.m. Board Meeting, Hollywood Beach Hotel Theatre
- 12:30 p.m. Luncheon, Main Dining Room, honoring Mrs. David B. Allman, President of the Woman's Auxiliary to the American Medical Association and Mrs. Robert C. Haynes, President of the Woman's Auxiliary to the Southern Medical Association. All doctors' wives invited.
- 4:00 p.m. Tea and Fashion Show, Flamingo Room, honoring Mrs. David B. Allman and Mrs. Robert C. Haynes. All doctors' wives invited. Hostesses, the Woman's Auxiliary to the Broward County Medical Society.
- 9:00 p.m. Smoker—Hollywood Beach Hotel—Patio near the Pool

Tuesday, April 25

HOLLYWOOD BEACH HOTEL—THEATRE

- 9:30 a.m. General Auxiliary Session
Call to Order, Mrs. Charles F. Henley, President
Invocation, The Reverend Harold C. Williamson, Hollywood
Pledge of Auxiliary, Mrs. Merritt R. Clements, Tallahassee
Address of Welcome, Mrs. S. Elliott Wilson, Ft. Lauderdale
Response, Mrs. C. Robert DeArmas, Daytona Beach
Presentation Convention Chairmen and Committee
Introductions
In Memoriam, Mrs. Gordon H. Ira, Jacksonville
Roll Call
Reading of Minutes, Belleair Convention
Convention Rules of Order, Mrs. Richard F. Stover, Miami
Address of the President, Mrs. Charles F. Henley, Jacksonville
Reports, Officers and Chairmen
Address, Dr. Herbert E. White, St. Augustine
Credentials and Registration
Announcements

(Continued on page 584)

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ALTON OCHSNER, M.D., GUEST SPEAKER

Born in Kimball, S. D., on May 4, 1896, Dr. Alton Ochsner received his academic training at the University of South Dakota, and his medical degree from the Washington University School of Medicine in St. Louis in 1920. After completing a medical internship at Barnes Hospital in that city and a surgical internship under Dr. A. J. Ochsner, his uncle, at Augustana Hospital in Chicago, he served as exchange surgical assistant at Kantonsspital, University of Zurich, Zurich, Switzerland, and Staetisches Krankenhaus, University of Frankfurt, Frankfurt-am-Main, Germany.

Upon entering surgical practice in Chicago in January 1925, Dr. Ochsner became Instructor in Surgery and Surgical Pathology at Northwestern University Medical School. In April 1926 he went to the University of Wisconsin Medical School as Assistant Professor of Surgery, serving in that capacity until July 1927, when he became Professor of Surgery and Director of the Department of Surgery, Tulane University of Louisiana School of Medicine, New Orleans. Since July 1928 he has served as William Henderson Professor of Surgery and Chairman of the Department of Surgery in that institution. Eight years ago he founded the internationally known Ochsner Clinic in New Orleans.

This eminent surgeon holds active membership in fourteen medical societies in this country and honorary membership in an even greater number in the United States, Mexico, Cuba, Costa Rica, Chile, Peru, Argentina and Nicaragua. He is a past president of the Southern Surgical Association (1944), Southeastern Surgical Congress (1942-1946), Society for Vascular Surgery (1947) and American Association for Thoracic Surgery (1947-1948). In 1946-1947 he served as chairman of the Section on Surgery, General and Abdominal, of the American Medical Association. Since 1936 he has been a regent of the American College of Surgeons.

A distinguished author, Dr. Ochsner has contributed over two hundred articles to medical journals, has published a book entitled "Varicose Veins" and has written sections in a number of medical publications. He also serves several leading surgical publications in an editorial capacity, being editor of The International Surgical Digest and coeditor of Surgery.

The Journal of the Florida Medical Association

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Seventy-Sixth Annual Meeting

Spacious, attractive and modern Hollywood-by-the-Sea will house the seventy-sixth annual convention of the Florida Medical Association, April 23-26. All features including the Smoker will be held in the luxurious Hollywood Beach Hotel. The ideally designed Sun Room will be the scene of the three General Sessions, four Scientific Assemblies and the two meetings of the House of Delegates. The complete program is published in preceding pages of this number of The Journal.

This year will see eighteen specialty groups convening during the weekend preceding the opening of the Association's meeting. All groups will hold one or more sessions on Sunday. One specialty society is scheduled for Saturday as well. Each group has been assigned a meeting room of such size as will be adequate for the attendance anticipated. The program for each of these groups appears in this issue.

Dr. Frederick K. Herpel, chairman of the Association's Committee on Scientific Work, together with the members of his committee, Drs. James R. Boulware, Jr., Jere W. Annis, James L. Borland and Carol C. Webb, has prepared the program for the scientific assemblies. This year there will be four scientific assembly meetings, one each on Monday forenoon and afternoon, and on Tuesday afternoon and Wednesday morning. Following a procedure inaugurated last year, many of the specialty societies will be represented on the Association's scientific program by out-of-state speakers

who will have previously addressed specialty groups.

Host to the members, delegates and guests will be the Broward County Medical Society. The local committee in charge has announced that arrangements have been completed for the annual Smoker on Monday night, April 23, planned with an atmosphere of tropical outdoors at the Patio near the swimming pool. Another event of the same evening at 6:00 p.m. will be the Alumni and Fraternity Suppers in the hotel's main dining room.

The annual dinner of the Association is scheduled for Tuesday night at the hotel. In addition to participating in these social events featured annually, the members and their guests will have opportunity for diversified entertainment and recreation which will include golf, trap shooting, beach and pool bathing, fishing and sea or shore exploratory excursions.

The Great Lounge of the hotel overlooking the ocean has been given over to the scientific and technical exhibits. Scientific exhibits will present a wealth of information of value to specialists and general practitioners alike. The numerous technical exhibits will invite careful inspection. Attendants will be on hand at each booth to answer the questions on the latest developments in equipment, drugs and other products displayed by the exhibiting firms.

Notice to Delegates and Committee Chairmen

The House of Delegates will hold its first 1950 meeting on Tuesday, April 25, at 9:30 a.m. in the Sun Room of the Hollywood Beach Hotel. The delegates are requested to assemble at the Credentials Committee table at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges. This table will be located at the entrance to the Sun Room. Delegates are to occupy seats in the designated section in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in another section of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of The Journal. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the speaker's table immediately after they are presented.

It is highly important that delegates and committee chairmen note the time, the date and the place of this first meeting of the House of Delegates. Register at 9:00 a.m. and convene at 9:30 a.m., Tuesday, April 25, in the Sun Room of the Hollywood Beach Hotel.

The second meeting of the House of Delegates will be held Wednesday, April 26, at 10:30 a.m. Delegates are required to fill out attendance cards for this meeting at 10:00 a.m. at the entrance of the Sun Room. These cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, at this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

Aureomycin and Aluminum Hydroxide Gel

Workers in a Florida hospital observed in the fall of 1949 that aureomycin did not have the expected therapeutic effect against *Streptococcus viridans* in a patient suffering from subacute bacterial endocarditis. At that time aluminum hydroxide gel was being given with the drug in order to lessen untoward gastrointestinal symptoms. Later,

when the same patient was treated with aureomycin but without aluminum hydroxide, the expected therapeutic effect, determined by susceptibility tests of the organism to the drug in vitro, was obtained. With this observation as a clue, aureomycin blood levels were determined during administration of a constant dosage of the drug from day to day, with and without simultaneous administration of aluminum hydroxide. The aureomycin blood level was found to be significantly higher when aluminum hydroxide was not administered.

In the November 26 issue of the Journal of the American Medical Association, under correspondence two letters are published stating that recent information indicates that "aluminum hydroxide gel does decrease the absorption of aureomycin and may interfere with its therapeutic effectiveness." Since that time further observations of the same tenor have been made.

Inquiry reveals that it is common practice to prescribe aluminum hydroxide gel with aureomycin inasmuch as their simultaneous administration will in some cases reduce epigastric distress, nausea and vomiting. It is understandable how distressed both physician and patient will become if they learn that the therapeutic effectiveness of an expensive drug has been destroyed when it could have been preserved. Likewise, most disturbing to the physician and the family will be the realization that the life of a patient with fulminating disease has been lost when it might have been saved.

The importance of this recent information cannot be stressed too strongly. If the several observations are confirmed, we shall do well to spread the news far and wide.

The Supreme Purpose of a Profession

To make available to society the very best of services needed, without reservation as to quality or question as to remuneration, is the supreme purpose of a profession. Realizing this purpose entails a certain amount of individual sacrifice in order to observe the standards of the group. Within such limits, however, the professional man secures that form of liberty which is most desirable from the American viewpoint, the liberty of pursuing his vocation freely under the encouragement of colleagues who proceed on professional presumptions like his own.

If the layman at times regards the resultant ethical principles as a recurrence of medieval cas-

uistry, he should be reminded that the interests of a profession are unique and can be fully understood only by its own members. As a matter of fact, the professional interests and activities need not be identical nor even similar to secure this bond. Among men of divers callings there is an interprofessional spirit which engenders peculiar understanding.

Recently, there was mailed to every member of the Florida Medical Association a booklet entitled "Principles of Medical Ethics of the American Medical Association." The opening statement is: "The prime object of the medical profession is to render service to humanity: reward or financial gain is a subordinate consideration." Perusal of this revised code offers the physician a refresher course in principles set forth not as "laws to govern" but as a "guide to correct conduct" — stimulating reading that engenders pride in a noble profession.

In the conclusion there is the reminder that these principles of medical ethics are presented for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. There is heartwarming truth in the final statement: "The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles."

It has been truly said that the confidence which arises from membership in a recognized and dignified profession, the assurance which comes to him who has not only imbibed from the fountains of such a profession but has also contributed substantially to its material foundations and to its social efficacy, contribute vitally to that sort of contentment and happiness which alone can be justified in an ethical society.



Rather than increase the dangerous imbalance of our national budget and the already too onerous burden of present taxes with the senseless addition of a new tremendous tax to finance medical service for all, including even those who are able and would prefer to handle their own needs, it seems logical and democratic to provide the means for extending the benefits of existing private insurance plans to those who cannot finance medical service by themselves.

The Meaning of Democracy

With all their rantings about democracy and the welfare of the "peepul," socialistic-minded politicians — in their avariciousness for more power and for the control of more votes — easily miss the chief meaning of democracy and of public welfare.

Hard as democracy is to define in its various detailed implications, we all seem to agree in principle on Lincoln's words at Gettysburg declaring democracy to be "a Government of the people, by the people and for the people." In his essay on Democracy, James Russell Lowell said: "This is a sufficiently compact statement of it as a political arrangement." What the politicians should remember is that "the people" includes everybody within the nation and that not one person or group should ever be deprived of any personal rights or be forced into the servitude of a compulsory arrangement for the care of their own needed services, medical, legal or any other, to the exclusive benefit of another group or groups.

The care of the health of the people is a legitimate concern of government. Nobody will deny that society as a whole should accept the responsibility of seeing that those who cannot afford its cost in full or even in part receive medical care with everybody assuming a proportionate share of the expense in the form of reasonable and just taxes.

What no one would consider as logical and democratic — except power-mad politicians and a few labor leaders in the same boat — is the arbitrary, confiscatory and tyrannical involvement of all the taxpayers in a crazy scheme to control all the medical care for all the people. Are we all so dumb and incapable, even those whose work and property produce substantial incomes, that we need the government in Washington to provide us with our pills and purges, our eyeglasses and wigs through the high wisdom of an ever growing army of clerks?

New Name for Hygeia

Hygeia, health magazine of the American Medical Association for lay readers, is now appearing with a number of changes, the most significant being a new name and a new editor. Beginning with the March issue, this informational magazine will be published as *Today's Health*, edited by Dr. W. W. Bauer who has succeeded Dr. Morris Fishbein, retired.

New Building for Jacksonville Blood Bank

Private medicine chalked up another decisive and imposing contribution to community and regional health during 1949 when the Jacksonville Blood Bank formally opened the doors of its new building for public inspection on October 16. Several hundred interested citizens shared in the impressive dedicatory services and then toured the spacious, ultramodern home, which provides an atmosphere of quiet dignity in keeping with the scientific program to which it is devoted.

On this auspicious occasion Dr. Lucien Y. Dyrenforth, who has consistently served the bank as vice president and medical director, reviewed the history of the organization since its inception as a vital factor in the national defense program in October 1942. Beginning modestly with a professional staff of three, the institution has grown by demand on its services until it now requires a staff of 15 highly qualified technicians and nurses.

Dr. Robert B. McIver, the president of the board of directors, pledged on behalf of the board an expanding program for the future embracing (1) establishment of a laboratory for experiment and research in the field of blood and blood products, (2) provision of a training program for physicians, nurses and technicians who seek to advance themselves in this special field, and (3) preparation, processing and making available to hospitals and other institutions, both in Jacksonville and elsewhere, the by-products and end products of blood.

In addition to its technical equipment for the drawing, storing and processing of blood and blood products, the building houses an auxiliary generator for emergency use. On the second floor there is a combined staff room and library.

A nonprofit organization with state and national affiliations, the Jacksonville Blood Bank now serves 16 counties and two nearby Georgia towns. It operates on a twenty-four hour, seven-day-a-week basis and maintains a most active and efficient donor reserve program. It has also been instrumental in establishing two subsidiary banks, one in the Flagler Hospital in St. Augustine and one in Gainesville, the Alachua County Bank located in its own building adjacent to the Alachua County Hospital. Assistance rendered the bank at Waycross, Ga., consisted of training its personnel.

The board of directors, composed of Dr. McIver, Dr. Dyrenforth, I. Beverly Nalle, treasurer,

Warren L. Jones, secretary, Mrs. Alfred I. duPont and Dr. Frederick J. Waas, takes particular pride in the accomplishments of the institution as well as in its new plant. Records of service from October 1942 through Dec. 31, 1948 account for 39,503 pints of blood received from donors, 30,777 transfusions and 5,091 units of plasma dispensed. Always there is maintained a sound reserve for local or regional emergencies.

Dr. Daniel Leavitt serves the bank in the capacity of consultant. Mrs. Dorothy Smith, R.N., the staff supervisor, also serves as liaison officer between the bank, the board of directors and the community. Mrs. Sarah Murphy is assistant supervisor and is responsible for the supervision of technical work in connection with the preparation of plasma.

Participation in Politics Clarified

The question has arisen as to whether or not the Florida Medical Association and its component county medical societies are authorized to oppose or endorse any political candidate. The answer is no.

As a citizen, an individual member has a perfect right to participate in politics, use his influence and efforts to have the candidate of his choice elected as well as to defeat a candidate whom he thinks is not qualified to hold a particular office.

On April 5, 1937, the House of Delegates of the Florida Medical Association adopted a resolution which definitely is the answer to the inquiries which have arisen. (See F.M.A. April, 1937 Journal, Page 497.)

RESOLUTION

Resolved, That no member of the Florida Medical Association shall sign any political paper or letter with his title as a member of this Association, or use the stationery of this Association for said purposes. This is not intended to keep any member from being active politically.

YOUR BLUE SHIELD

Annual Meeting of Blue Shield

The annual meeting of the Active Members of the Florida Medical Service Corporation will be held on Sunday, April 23, 1950, at 4:00 p.m. in the Library of the Hollywood Beach Hotel, Hollywood, Florida, in conjunction with the annual meeting of the Florida Medical Association. It is of utmost importance that all participating

physicians, as Active Members of the Corporation, attend the Blue Shield annual meeting, as it is their opportunity to learn first-hand the problems and activities of their Plan, and to have a voice in its administration.

Election of Directors

At the annual meeting, elections will be held for directors of the Corporation to fill the vacancies on the Board of Directors brought about by the expiration of several terms of office.

According to the By-Laws of the Florida Medical Service Corporation, the Board of Directors shall consist of eighteen directors, which may be decreased to not less than twelve, and increased to not more than twenty-four, to be chosen as follows: two participating doctors from each Medical District of the Florida Medical Association; two or more participating doctors from the Florida Medical Association's membership at large, and one or more laymen from each Medical District of the Florida Medical Association. All directors are elected by the Active Membership of the Corporation from nominees submitted by the Florida Medical Association, and serve for a period of three years. At the first annual meeting of the Corporation directors were elected to serve for terms of one, two and three years in order that an equal number of terms would expire each year thereafter.

Progress Reports

In addition to the election of directors, Progress Reports for the past year will be given by the President, Treasurer and Executive Director of the Plan. These reports should prove to be of vital interest to all Blue Shield physicians as they are the best means of judging the progress which is being made by Florida Blue Shield.

Discussion on Series 7 Contract

Following the presentation of the Progress Reports there will be a general discussion on the new Series 7 Contract which was first offered on Jan. 1, 1950. As there will undoubtedly be many questions asked about this new contract and many points clarified during the discussion, participating physicians should make every effort to attend this meeting and participate in the discussion.

Active Membership

It is not too late for participating physicians who are not now Active Members to make application to the Plan to serve in this capacity, and thereby become eligible to attend the annual meeting. Active Membership requires that no dues be paid and does not obligate the physician in any way.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Shaler Richardson of Jacksonville announce the birth of a son, Shaler, Jr., on Jan. 26, 1950.

Marriages

Dr. Henry Feintuch of Miami Beach and Miss Harriet Rebhun of New York City were married on Jan. 16, 1950.

Dr. William D. Futch and Mrs. Frances C. Partridge, both of St. Petersburg, were married on Dec. 2, 1949.

Deaths—Members

Dr. Thomas R. Purcell, Clearwater	Jan. 14, 1950
Dr. Ernst P. E. Sengstak, Daytona Beach	Dec. 5, 1949
Dr. John A. Toomey, Cleveland, Ohio	Jan. 1, 1950
Dr. Harry Hausman, Daytona Beach	Jan. 8, 1950

Deaths—Other Doctors

Dr. Donald T. Babcock, Los Angeles, Calif	Nov. 2, 1949
Dr. William G. DeVane, Groveland	Jan. 2, 1950
Dr. James C. Fleming, Pittsburg, Pa.	Nov. 13, 1949
Dr. Edward L. Myers, Woonsocket, R. I.	Nov. 10, 1949
Dr. Stanley H. Nichols, Asbury Park, N. J.	Nov. 14, 1949

STATE NEWS ITEMS

Dr. Webster Merritt of Jacksonville was guest speaker on a recent program sponsored by the Creative Reading Division of the local Woman's Club. Dr. Merritt is the author of numerous medical and historical articles and books.

Dr. N. Worth Gable of St. Petersburg recently spoke before the local Optimist Club. Dr. Gable explained the steps taken in helping, through operations and radium treatments, persons with impaired hearing. He cited examples of children with a high percentage of inability to hear being made normal through restoration of hearing.

Association members attending the 35th annual meeting of the Radiological Society of North America at Cleveland, December 4-9 include: Theodore M. Berman, Miami Beach, Harold O. Brown, Tampa, C. Robert DeArmas, Daytona Beach, J. Maxey Dell, Jr., Gainesville, Charles McC. Gray, Tampa, Floyd K. Hurt, Jacksonville, Alfonso F. Massaro, Tampa, John N. Moore, Ocala, Frazier J. Payton, Miami, Gerard Raap, Miami and Hugh G. Reaves, Sarasota.

Dr. J. Lloyd Massey of Quincy has returned to his practice following a trip to New Orleans where he made observations at the Ochsner Clinic and Foundation Hospital.

Dr. Donald S. Bryant, Lakeland, in a recent address before the Auburndale Civitan Club discussed the need of a hospital in that city. Dr. Bryant went into considerable detail on his suggestions as to the methods of organization, operation and management of the proposed hospital.

Dr. Walter C. Payne, president, on January 23 spent the entire day in the headquarters office in connection with Association business.

A Seminary on Diabetes will be held in Tampa on March 20 and 21 under the auspices of the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health.

Dr. Donald W. Smith, president of the Dade County Medical Association has announced the appointment of John L. Rhodes, Jacksonville, as executive secretary of the local association. Mr. Rhodes is a native Floridian and graduated from the U. S. naval academy in 1929. He served with the Navy for 12 years and again through World War II. He has held outstanding positions with commercial organizations and Chambers of Commerce.

Drs. Harold E. Winchester and Walter H. Winchester of Dunedin spoke recently before a special meeting of the Clearwater Beach Private Duty Section, Florida State Nurses Association. The doctors discussed the use of new drugs and medical nursing.

Dr. Charles McD. Harris, Jr., West Palm Beach, recently addressed the local medical society auxiliary on "The Medical Society's Program of Voluntary Hospital and Health Insurance."

Dr. M. Eldridge Black of Clearwater was a guest speaker at a joint meeting of the private duty and hospital staff nurses. Dr. Black discussed new techniques and new drugs used in pre-operative and postoperative care of hospital patients.

Dr. Jack M. Waldrep of Ocala was one of the speakers on a local Parent-Teacher Association program. Dr. Waldrep spoke on "Medical Problems of Children."

Dr. Webster Merritt of Jacksonville discussed the role of modern medicine in the economic development of Jacksonville and the state at a recent meeting of the Men's Fellowship of the local First Presbyterian Church.

Dr. Will L. Wood of New Smyrna Beach recently has been retired from the Army of the United States in the rank of Colonel. Colonel Wood is now residing at his home at 114 S. Riverside Drive.

Dr. Maurice I. Edelman of Miami recently opened an office at 420 Lincoln Road, Miami Beach for the practice of Ear, Nose, Throat and Plastic Surgery.

Dr. William C. Thomas of Gainesville was one of four local citizens given recognition for their efforts and accomplishments at a special "Mid-Century" program by the local Rotary Club. Dr. Thomas was recognized for an outstanding record of over twenty-five years of service to the community.

Dr. Lorenzo L. Parks, director of Field Technical Staff and Acting Director of the Bureau of Preventable Diseases, Florida State Board of Health, attended the American Medical Association meeting on rural health, February 3-4 in Kansas City, Missouri.

Woman's Auxiliary Program

(continued from page 576)

- 12:30 p.m. Annual Luncheon honoring Past Presidents, Main Dining Room
Guests of honor, Dr. Walter C. Payne, Dr. Herbert E. White, Dr. Frank Slaughter. Open to all doctors' wives.
- 2:00 p.m. Afternoon Session, Theatre
Reports of County Presidents
Election of Delegates to A. M. A. Convention
Report of nominating committee, Mrs. Lee E. Parmley, Winter Haven
Election of officers
Installation of officers, Mrs. Leigh F. Robinson, Ft. Lauderdale
Presentation of President's Pin. Mrs. William C. Williams, Jr., West Palm Beach
Courtesy Resolutions, Mrs. Herschel G. Cole, Tampa, and Mrs. Thomas C. Kenaston, Cocoa
- 3:00 p.m. Garden Ramble
- 7:00 p.m. Association Dinner—Main Dining Room

COMPONENT SOCIETY NOTES

Bay

Members of the Bay County Medical Society heard a paper on surgical diseases of the chest by Dr. Samuel Windham, of Dothan, Alabama at their regular January meeting.

Broward

The Broward County Medical Society, host to the 1950 annual state meeting, has selected the following officers for the ensuing year: Dr. Richard A. Mills, president; Dr. M. Austin Lovejoy, president-elect; Dr. Lloyd U. Lumpkin, vice president; Dr. Norris M. Beasley, secretary, and Dr. Julius F. Boettner, treasurer.

Duval

The guest speaker at the January meeting of the Duval County Medical Society was Dr. Katherine Dodd, associate professor of pediatrics at the University of Cincinnati College of Medicine. Her subject was "Tetany in Infancy and Childhood."

Franklin-Gulf

At the January meeting of the Franklin-Gulf County Medical Society held in Apalachicola, the following officers were elected for 1950: Dr. Donald H. Anderson, Wewahitchka, president; Dr. William P. Blackmon, Apalachicola, vice president, and Dr. John W. Hendrix, Port St. Joe, secretary-treasurer.

Guest speaker for the evening was Dr. Clarence M. Sharp of Jacksonville. The following members were present: Drs. Donald H. Anderson, Wewahitchka; Terry Bird, William P. Blackmon and James A. Steely, Apalachicola; and John W. Hendrix and Albert L. Ward, Port St. Joe.

Lake

Officers to represent the Lake County Medical Society for 1950 are: Dr. Glendy G. Sadler, president; Dr. Rabun H. Williams, vice president, and Dr. Lawton F. Douglass, secretary-treasurer.

Marion

Over thirty-five of the members, wives and guests of the Marion County Medical Society attended the January meeting which was held at the 1890 House in Ocala. President Cumming announced the appointment of Dr. Robert E. Thompson as Legislative Officer to act with the state legislation and public policy committee of which Dr. Eugene G. Peek, Sr., is chairman. At the scientific session that followed, Dr. James B.

O'Connor from Jacksonville presented an interesting paper on psychiatry.

The following members were present: Drs. William H. Anderson, Jr., Matthew Arnow, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, John D. Lindner, Carl S. Lytle, William J. McGovern, John N. Moore, John P. Moore, Robbins Nettles, Eugene G. Peek, Jr., Ralph E. Russell, James L. Strange, Thos. H. Wallis and Harry F. Watt. The guests included Dr. and Mrs. James B. O'Connor and Mrs. Charles F. Henley, Jacksonville, and Dr. and Mrs. J. J. Cheleden, Lake Weir.

Polk

The first meeting of 1950 of the Polk County Medical Society was held in the Polk Hotel, Haines City, Wednesday night, January 11. This was a combined meeting of the county medical society and their auxiliary.

Guest speaker at the meeting was Dr. Robert B. Greenblatt, professor of Endocrinology, University of Georgia School of Medicine, Augusta, Ga. His topic was "Some Common Disorders of the Pituitary Gland." Other guests were doctors from Lake, Highlands and Orange counties and local druggists.

Taylor

The Taylor County Medical Society has elected the following officers for 1950: Dr. George H. Warren, president; Dr. Ralph J. Greene, vice president, and Dr. Walter J. Baker, secretary-treasurer. The Taylor County Society is among the first to obtain 100% on paid dues for 1950.

Volusia

At its regular January meeting the Volusia County Medical Society heard a talk by Dr. William O. Fowler of Orlando on methods of treating cancer.

Walton-Okaloosa

The Walton-Okaloosa County Medical Society has paid 100% state dues for 1950.

Washington-Holmes

Newly elected officers for 1950 of the Washington-Holmes County Medical Society are Drs. N. J. Dawkins, president, and Baylye W. Dalton, secretary-treasurer. All members of this society have paid their 1950 dues.

THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

ELI LILLY AND COMPANY—1

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit. Many new therapeutic developments will be featured and literature on these products will be available. Visiting physicians will be aided in every way possible.

THE WM. S. MERRELL COMPANY—2

For prompt symptomatic relief (85-90% of cases) of bronchial asthma, Merrell presents Nethaphyl, combining a more effective bronchodilator, a better tolerated myocardial stimulant and a mild sedative. An extensive 8-year clinical experience has demonstrated its essential freedom from central stimulation or other side effects, effectiveness in epinephrine-fast cases, no increased tolerance or urinary retention, and non-interference with desensitization therapy. In one study, 87% of patients preferred Nethaphyl over other drugs.

PARKE, DAVIS & COMPANY—3

Members of the Parke, Davis & Company Medical Service Staff will be on hand at our commercial exhibit for consultation and general discussion of the Products classified in our Pharmaceutic, Antibiotic, and Biologic Lines. Important Specialties, such as Chloromycetin, Penicillin S-R, Benadryl Group, Vitamin Products, Antibiotics, Oxytel, Thrombin Topical, Influenza Virus Vaccine, and other Biologics will be featured. You are cordially invited to visit our booth with the assurance that your interest will indeed be very much appreciated.

CIBA PHARMACEUTICAL PRODUCTS, INC.—4

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, invite you to visit their exhibit for latest information on Priscoline (formerly known as Priscol), a valuable adjunct to the treatment of peripheral vascular disease. Pyribenzamine HCl, the antihistaminic drug for prevention and relief of anaphylaxis and many forms of allergy will also be featured. Representatives in attendance will gladly answer any questions concerning these and other Ciba products.

U. S. VITAMIN CORP.—6

Our exhibit demonstrates the greatest vitamin technological advance of the present decade—"oil-in-water" multi-vitamin solutions. It includes Vi-Syneral Injectable, an aqueous parenteral multi-vitamin solution, ready for immediate injection and the original oral aqueous multi-vitamin formula, Vi-Syneral Vitamin Drops. Also, professional samples of Methiscol, Vi-Syneral Therapeutic, Tri-Sulfanyl, Poly-B, Vi-Litron and others will be available.

ANDERSON SURGICAL SUPPLY COMPANY—7

Anderson Surgical Supply Company, with stores in Jacksonville, Tampa and St. Petersburg will have on display many things of interest to the physicians of Florida. Representatives of the various branches will be on hand to greet the doctors. The firm is in its 33rd year of operation and has rendered an outstanding service to the medical profession in Florida over these years.

SHARP & DOHME, INC.—9

Visitors attending the Florida Medical Association meetings are cordially invited to visit the Sharp & Dohme exhibit. Stable, portable Lyovac Normal Human Plasma irradiated to destroy viral contaminants that might cause homologous serum hepatitis merits your attention. Unusual Specialties include Cremo-sulfonamides, pleasantly flavored, palatable suspensions of the most effective systemic and enteric sulfonamides, and Delmor, a delicious nutrient powder, also will be of major interest.

THE BORDEN COMPANY—10

Meet Biolac, a liquid modified milk for infant feeding; Dryco, with its formula flexibility; Mull-Soy, for your milk allergic patients; powdered whole milk, Klim; Gerilac, a vitamin-fortified powdered milk for well-rounded nutrition; the improved milk sugar, Beta-lactose; and the Merrell-Soule Protein and Lactic Acid Milks. Borden men are pleasant men.

MCCALL-RISING, INC.—12

Our firm. Orthotist and Prosthesis technicians, are certified by the American Board of Certification. We also have a certified suction socket fitter for artificial limbs. Our firm is well established to render prompt and efficient service on all appliances; the latest approved devices are used, along with the best of materials.

BYRON THOMPSON & COMPANY

MEDICAL SUPPLY COMPANY—13-14

You are cordially invited to stop and visit our booths at the annual Convention of the Florida Medical Association, Hollywood Beach Hotel, April 23-26. We will exhibit the latest in equipment and accessories to assist you in rendering the best possible service to your patients. We will be present, together with our representatives, to welcome and be of assistance to you.

ABBOTT LABORATORIES—17

Abbott Laboratories will exhibit a number of its leading products, such as Nembutal, a short-acting barbiturate; rapid repository penicillin for aqueous injection; Aerohalor, Abbott's powder inhaler; Pentothal Sodium, for intravenous anesthesia; Norisodrine, for the reduction of bronchospasm in asthma, and a number of single and multiple vitamin products.

EATON LABORATORIES, INC.—18

Recent specialties include, the latest additions to the Furacin Family: Furacin Anhydrous Ear Solution for bacterial otitis and Furacin Vaginal Suppositories for bacterial cervicitis and vaginitis and pre and postoperative vaginal surgery; Tripazine—triple sulfa tablet to minimize crystalluria; Aspogen—the aluminum—amino acid salt with prompt and prolonged action for treatment of peptic ulcer; Paracin—scabicide, pediculicide and ovide, effective in one application. Results of recent clinical studies of the efficacy of Lorophyn Suppositories will be available.

WINTHROP-STEARNES, INC.—19

Winthrop-Stearns, Inc., New York, invite you to visit its booth, where the following products will be featured: Aralen, effective antimalarial, also specific for extra-intestinal (hepatic) amebiasis; Milibus, new, virtually non-toxic amebicide; Sulfamylon, new sulfonamide for topical use with wide antibacterial range (including anaerobes, gas gangrene), not inhibited by pus. Also available with Streptomycin—Mebalar, sedative and antiepileptic, produces tranquility without drowsiness.

Radiopaque diagnostic medium . . .
Original development of Searle research

Iodochlorol[®]

BRAND OF CHLORIODIZED OIL

now
council
accepted



Clear visualization of body cavities—for the roentgen investigation of pathologic disorders involving sinuses . . . bronchial tree . . . uterus . . . fallopian tubes . . . fistulas . . . soft tissue sinuses . . . genitourinary tract . . . empyemic cavities.

Iodochlorol is notably free from irritation, free-flowing, highly stable and has pronounced radiopaque qualities. It contains the two halogens, iodine, 27 per cent, and chlorine, 7.5 per cent, organically combined with a highly refined peanut oil.

Iodochlorol is available in bottles containing 20 cc. of the radiopaque medium; each one is packed in an individual carton. G. D. Searle & Co., Chicago 80, Illinois.

Searle

RESEARCH IN THE SERVICE OF MEDICINE

An Observation on the Accuracy of Digitalis Doses

Withering made this penetrating observation in his classic monograph on digitalis: "The more I saw of the great powers of this plant, the more it seemed necessary to bring the doses of it to the greatest possible accuracy."¹

To achieve the greatest accuracy in dosage and at the same time to preserve the full activity of the leaf, the total cardioactive principles must be isolated from the plant in pure crystalline form so that doses can be based on the actual weight of the active constituents. This is, in fact, the method by which Digilanid® is made.

Digilanid contains all the *initial* glycosides from *Digitalis lanata* in crystalline form. It thus truly represents "the great powers of the plant" and brings "the doses of it to the greatest possible accuracy".

Clinical investigation has proved that Digilanid is "an effective cardioactive preparation, which has the advantages of purity, stability and accuracy as to dosage and therapeutic effect."²

Average dose for initiating treatment: 2 to 4 tablets of Digilanid daily until the desired therapeutic level is reached.

Average maintenance dose: 1 tablet daily.

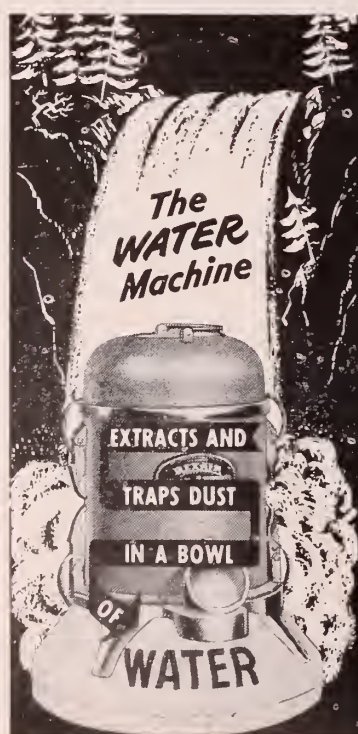
Also available: Drops, Ampuls and Suppositories.

1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, *Am. J. M. Sc.* 209: 33-41 (Jan.) 1945.

Literature giving further details about Digilanid and Physician's Trial Supply are available on request.

Sandoz Pharmaceuticals

DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, NEW YORK



Rexair Traps Household Dust in Water

WASHES AIR, HUMIDIFIES, VAPORIZES, DOES ALL
VACUUM CLEANING WORK, AND EVEN SCRUBS FLOORS!

Water is the secret of Rexair's dust-filtering action. Rexair—and only Rexair—passes the stream of dust-filled air completely through a churning bath of water, discharging clean, humidified air into the room. Rexair direct factory sales and service branches are listed in phone books of principal cities of United States and Canada. Call your local branch or write direct to:

REXAIR DIVISION, Martin-Parry Corporation
Box 964 MB3 TOLEDO, OHIO

➔ **EXCLUSIVE WITH Rexair**
Fully Guaranteed by a 69-Year-Old Company
OVER 1,000,000 SATISFIED USERS

PICKER X-RAY CORPORATION—21

Picker X-Ray Corporation will exhibit the new practical x-ray unit at a popular price—The Meteor. A patented tilting table top feature provides for rapid and easy conversion from radiography to fluoroscopy in either horizontal or vertical positions.

SURGICAL EQUIPMENT COMPANY—22

Surgical Equipment Company of Miami will exhibit the latest of surgical instruments and will display the Edin Electrocardiograph (direct writing). We extend a cordial invitation to all physicians to visit our booth. See our display and demonstrations.

SANDOZ PHARMACEUTICALS—24

Physicians attending the Florida Medical Association convention are cordially invited to visit the Sandoz Pharmaceuticals display which will feature the following: Cafergone, the first effective oral preparation for the treatment of migraine and related headaches and Bellergal, a time-tested preparation for use in functional disorders. Other products displayed at this convention are Belladenal, Mesantoin, Dihydroergotamine—D.H.E. 45 and Iperaldrine. A new handbook listing our products will be available and representatives in attendance will gladly answer any questions about these and other Sandoz products.

THE UPJOHN COMPANY—26

The Upjohn exhibit will present the anticoagulant family: Heparin, Depo-Heparin, and Dicumarol, with particular emphasis placed upon Depo-Heparin. When heparin is prepared in a gelatin vehicle (Depo-Heparin) and administered intramuscularly, markedly prolonged effects are obtained. A single injection of 1 cc. (200 mg.) of Depo-Heparin will prolong the blood coagulation time for about twenty-four hours.

BURROUGHS WELLCOME & CO. (U.S.A.), INC.—27

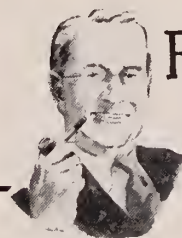
Burroughs Wellcome & Company will feature a completely new type antihistaminic, perazil brand Chlorcyclizine Hydrochloride. Perazil differs chemically in that it is a piperazine rather than a conventional ethylenediamine compound. Ask our representatives about the advantages of Perazil. We will also feature Wellcome brand Globin Insulin, the accepted intermediate acting insulin, and Digoxin, for safe, predictable digitalization.

S. H. CAMP & COMPANY—28

S. H. Camp & Company, Jackson, Michigan, will display a complete line of Camp Anatomical Supports for prenatal, postnatal, visceroptosis, sacroiliac, hernia and other specific conditions. Experts from the Camp staff will be in attendance to answer questions pertaining to the scientific application of these supports and to advise regarding the availability of them in authorized service departments of stores throughout the country.

ENDO PRODUCTS, INC.—29

The Endo booth will feature Vifort, a new type of water-dispersible polyvitamin drop, and Mesopin, a selective gastrointestinal antispasmodic. Clinical work indicates that the aqueous form of vitamin A, as found in Vifort, is more readily and completely utilized than vitamin A in oil solution. Mesopin is a specialized antispasmodic whose action is predominately directed toward the gastrointestinal tract. Its selective action permits more direct management of hyperactivity and spasticity without causing the undesirable and uncontrollable effects of atropine, belladonna or related antispasmodics.



From where I sit by Joe Marsh

Gabby Enjoys Going to the Dentist

One of my molars was giving me a bad time Tuesday, so I slipped over to Doc Jones, hoping to catch him free. When I arrived, Gabby Jackson was sitting there reading a magazine. I said hello to Gabby and he nodded.

Doc comes out and says I'm next. "Wait a minute," I says. (My tooth seemed to have stopped aching.) "How about Gabby—doesn't he have an appointment?" Doc smiles and says, "Gabby? Why, he's got the finest teeth in the county. He just comes up here and reads magazines when he's in town!"

As Doc went to work he told me he's glad to have Gabby read magazines . . . they might not all be fresh off the newsstand, but if Gabby—or anyone—wants to while away some time, who is he to stand in his way?

From where I sit, this "live and let live" spirit helps make America what it is. If I prefer a friendly glass of beer with my supper and you happen to prefer milk—who's to say one's right and the other wrong?

Joe Marsh

simplify the
mother's
problem

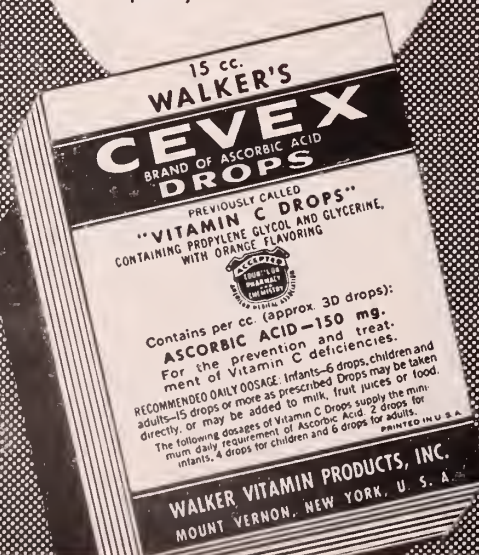
CEVEX
TRADEMARK

Brand of
**ASCORBIC
ACID DROPS**
Previously called
VITAMIN C DROPS

Makes it easy to
administer adequate
amounts of vitamin C to
infants and young children.
Each drop supplies 5 mg.
of vitamin C.

CEVEX may be added to
milk, fruit juices, or food.

To ensure that your patients
receive the vitamin C drop
that is Council accepted
specify:



TABLEROCK LABORATORIES—30

We extend a very cordial invitation to each of you to visit us at our exhibit, where you will find many Pharmaceutical advancements on display, including Co-m-nine, a very potent chocolate flavored colloidal suspension of Choline and Methionine.

WALKER VITAMIN PRODUCTS, INC.—31

Precalcin, the complete pre-natal product supplying all essential vitamins and minerals, will be featured at this exhibit. Precalcin is unique in that the capsules contain a dry powder fill with no fish liver oils, thereby providing excellent tolerance and patient appeal. Other featured products include Cevex (Council Accepted Vitamin C Drops), Histacin (cold therapy) and Neodrops (water miscible multivitamins). Other vitamin and amino acid products will also be displayed and representatives present will be glad to discuss all aspects of current therapy in these fields.

KELEKET X-RAY OF FLORIDA—32

Keleket X-Ray of Florida is proud to exhibit for the 22nd consecutive year at the Annual Florida Medical Association Meeting in Hollywood. We will be happy to see many of our old friends. Equipment of latest development by Keleket-Liebel-Flarsheim and Cambridge Instrument Company will be on exhibit and we invite your inspection without obligation to purchase.

THE NATIONAL DRUG COMPANY—33

Resinat, Protinal Powder, AVC Improved and Hesperidin-C will be the products featured at the booth of The National Drug Company. You are cordially invited to our booth where trained representatives will be in attendance to answer any questions concerning National's vast array of pharmaceutical, biological and biochemical products.

ORTHO PHARMACEUTICAL CORPORATION—34

Ortho cordially invites you to visit its booth. Featured will be the Ortho Kit, a new, convenient, woven lumite, zipper bag containing the requisites for proper conception control. The complete line of Ortho gynecic pharmaceuticals will also be on display. Ortho representatives will be on hand to greet you.

PHILIP MORRIS & CO., LTD., INC.—35

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

AMERICAN OPTICAL COMPANY—36

The American Optical Company will present an exhibit of some of their later developments of "Scientific" and "Ophthalmic" instruments and equipment. All members and guests of the Florida Medical Association are cordially invited to visit this booth for explanations and demonstrations by trained instrument representatives of the American Optical Company.

THE COCA-COLA COMPANY—39-40

Ice-cold Coca-Cola served through the cooperation and courtesy of the Ft. Lauderdale Coca-Cola Bottling Company and the The Coca-Cola Company.

H. G. FISCHER & COMPANY—41

You are invited to inspect H. G. Fischer & Company's modern, efficient, low priced x-ray and physical therapy equipment. Let us point out many features of advantage in these representative units and other models not on display and explain their extremely liberal terms of sale. You are welcome, no obligation.

WYETH, INC.—42

Basaljel — a newly developed preparation for the prevention of renal stones, and S.M.A. — the standard, council-accepted complete food formula for infants, will be featured along with such widely prescribed ethical specialties as Amphojel, Kaomagma with Pectin, Petrogalar and Meonine. Trained representatives will be on hand to supply literature and samples of many outstanding therapeutic agents.

A. S. ALOE COMPANY—44

Your Aloe representative will be happy to welcome you at his booth. He has on display a representative cross-section of the surgical and laboratory equipment and supplies stocked by the "world's largest surgical supply house." Featured are many new items which you will want to see and have demonstrated.

CAMEL CIGARETTES—45

Camel Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking Camel Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking Camels."

G. D. SEARLE & CO.—46

You are cordially invited to visit the Searle booth where our representative will be happy to answer any questions regarding Searle Products of Research. Featured will be Dramamine for the prevention and active treatment of motion sickness; Alidase, for hypodermoclysis; Ruphyllin, for abnormal capillary fragility; Hydryllin, new and effective antihistaminic, as well as such time-proven products as Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine and Pavatrine with Phenobarbital.

MEAD JOHNSON & COMPANY—48

Dextri-Maltose, Oleum Percomorphum, Pabulum, Pabena, Olac and other Mead Products used in Infant Nutrition will be on display at the Meads Johnson Exhibit at your Florida Medical Association Meeting. Protenum, a new high protein product, will be displayed. Also, Lanalac, for low sodium diets. Our representatives at the Exhibit will be glad to discuss with you the new improvements of Amigen and Amisets.

PET MILK COMPANY—49

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

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SURGERY—Intensive Course in Surgical Technique, Two Weeks, starting March 20, April 17, May 15. Surgical Technique, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 6, April 3, May 1. Basic Principles in General Surgery, Two Weeks, starting April 3. Personal Course in General Surgery, Two Weeks, starting April 17. Surgery of Colon & Rectum, One Week, starting April 10, May 15. Esophageal Surgery, One Week, starting June 5. Breast & Thyroid Surgery, One Week, starting June 26. Thoracic Surgery, One Week, starting June 12. Gallbladder Surgery, Ten Hours, starting April 24. Fractures & Traumatic Surgery, Two Weeks, starting March 20, June 12.

GYNECOLOGY—Intensive Course, Two Weeks, starting March 20, April 17. Vaginal Approach to Pelvic Surgery, One Week, starting April 3.

OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31. Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Electrocardiography & Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastro-Enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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Attending Staff of Cook County Hospital

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Chicago 12, Illinois**

M & R DIETETIC LABORATORIES, INC.—53

Similac Division, M & R Dietetic Laboratories, Inc., will display Similac, a food for infants, and Cerevim, a cereal food. Our representatives will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

J. B. LIPPINCOTT COMPANY—54

J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott Selected Professional Books are undertaken.

BOOKS RECEIVED

HUMAN GROWTH, THE STORY OF HOW LIFE BEGINS AND GOES ON. By Lester F. Beck, Ph.D. Price, \$2.00. Pp. 124. New York: Harcourt, Brace and Company, 1949.

Based on the educational film of the same title, this book is the result of extensive psychologic research sponsored over a period of years by the E. C. Brown Trust, a foundation established in Oregon a decade ago for social hygiene education. The author is associate professor of psychology at the University of Oregon.

This carefully planned, psychologically sound and honest book about sex is written for boys and girls just entering their teens and also for those adults who have the important task of helping young people achieve a wholesome view of life and growth. Here in simple straightforward terms are all the important facts about male and female human growth: how a baby is conceived, how it grows inside the mother's body, how it is born and develops into a normal human being.

The primary purpose of the book is to create a healthy mental attitude in adults and children alike by a simple, honest telling of the story of human growth, and by providing a sound basis for intelligent discussion of this all-important subject.

THE PHYSIOLOGY OF THOUGHT, A FUNCTIONAL STUDY OF THE HUMAN MIND IN ACTION. By Harold Bailey, M.D. Price, \$3.75. Pp. 313. New York: The William-Fredrick Press, 1949.

The various relationships existing between mental processes and other phenomena are unfolded in this study of human thought. The author presents the nervous system in general, as well as that more highly specialized branch which concerns mental function, with a direct approach to the construction of personality; he discards much general physiology, however, in the rewarding attempt to capture the interest of the lay reader. A practical sociological analysis of mental and emotional makeup results.

Dr. Bailey maintains that mental deficiencies in various degrees may exist without becoming a threat to the life and nutrition of the body in general. On this thesis, he offers an enlightening discussion on the possibilities of cutting through "fixed" habits and establishing new patterns.



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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Marianna
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Ocala
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Ft. Myers
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	West Palm Beach
Florida Specialty Societies			
Allergy Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Heart Association	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewitt, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 3, '50
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, June 25-27, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 26, '50
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, March 30-31, '50
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	St. Petersburg, April 5-7, '50
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	R. J. Wilkinson	R. T. Beasley, Atlanta	Washington, D. C., Mar. 6-9, '50
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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A

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
				Total	Paid	
Bay	Daniel M. Adams, Jr., M.D. Box 593 Panama City	Jack Corbitt, M.D. Box 961 Panama City		16	3	A-1-50 William P. Hixon, M.D. Pensacola
Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	64	6	
Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	3rd Tuesday Odd Months	6	0	
Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	13	
Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	
Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	4	6	
Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		6	5	
Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	0	
Taylor *Davie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	201

B

Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 331 W. University Ave. Gainesville	Henry H. Graham, M.D. 749 E. Main St., N. Gainesville	2nd Tuesday 8:00 P.M.	41	32	B-3-50 Charles C. Grace, M.D. St. Augustine
Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	246	27	
Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	29	19	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	1	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	9	
St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	14	2	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	17	13	
Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	20	17	
Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	134	7	
Seminole	Charles L. Park, M.D. 109 W. 17th St. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	52	5	584

C

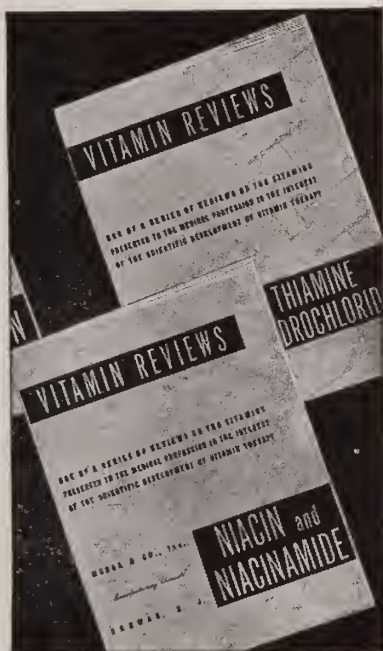
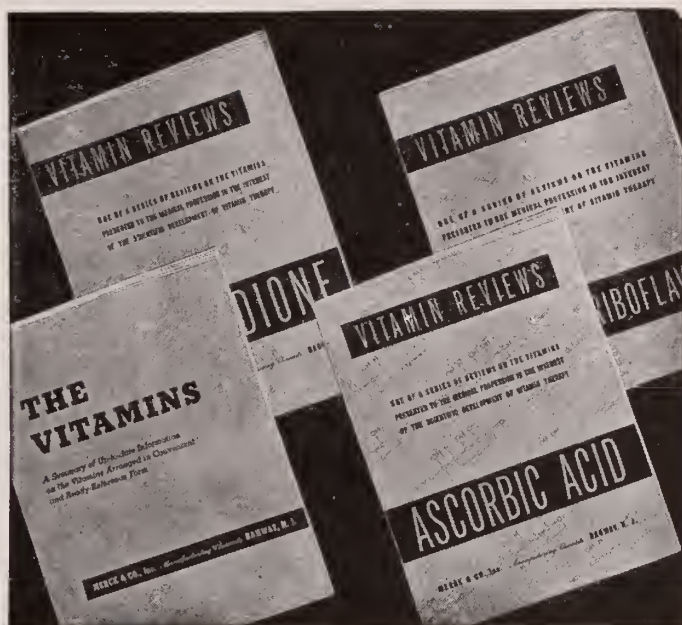
Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	153	15	C-5-51 M. Crego Smith, M.D. Clearwater
Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	20	5	
Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	11	9	
Pinellas	Albert R. Frederick, M.D. 408 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	168	151	
Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	25	3	
DeSoto-Hardee- Highlands- Charlotte-Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	27	2	C-6-50 H. Quillian Jones, M.D. Ft. Myers
Lee *Collier, Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. McCrory Bldg. Punta Gorda	3rd Monday 7:30 P.M.	22	1	
Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	80	31	506

D

Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	0	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	96	64	
St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	11	0	
Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	71	51	D-8-51 S. Marion Salley, M.D. Miami
Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	521	214	
Monroe	Herman K. Moore, M.D. 600 Elizabeth St. Key West	Wallace H. Mitchell, M.D. 217 Duval St. Key West	2nd Thursday 8:00 P.M.	12	10	719

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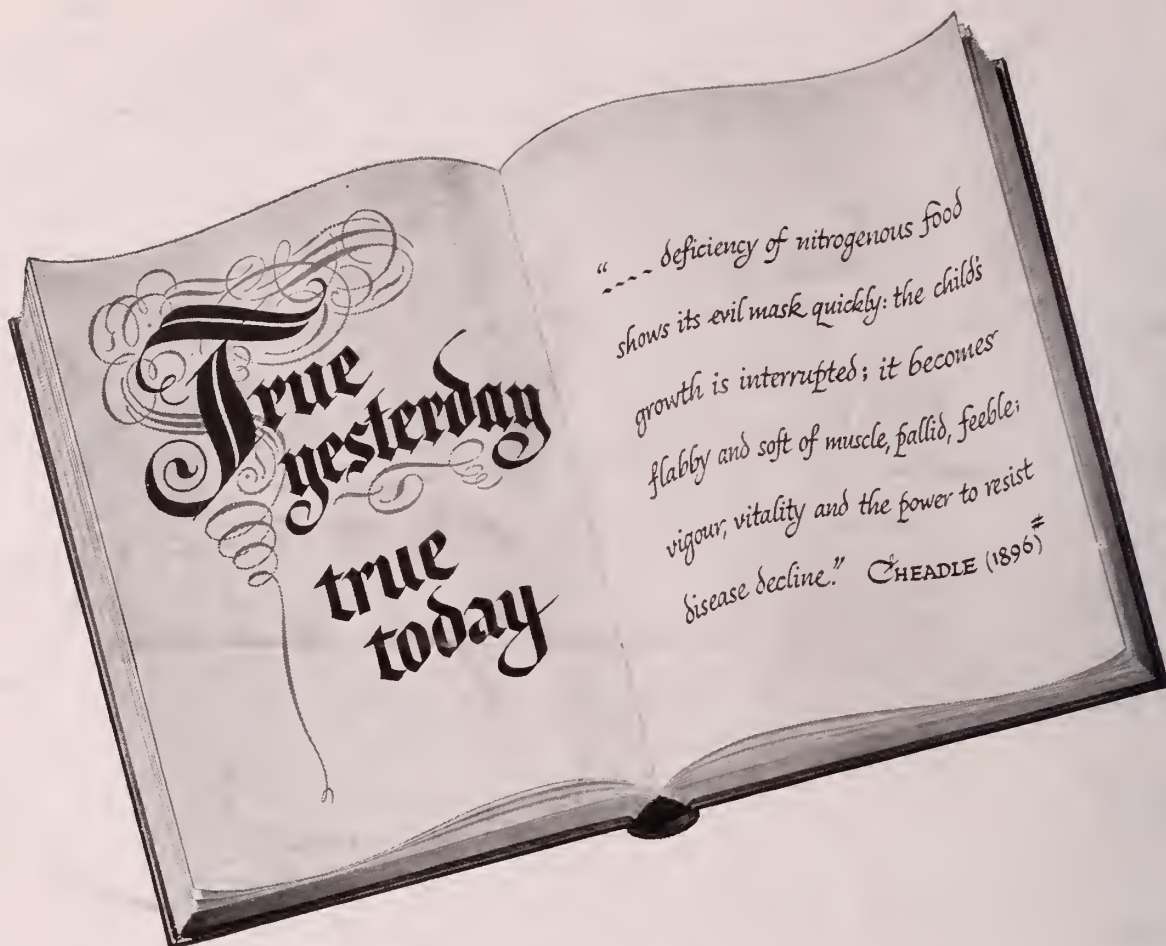
Partial Index of Contents

- Factors that produce avitaminosis.
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#Cheadle, W. B.: Artificial Feeding of Infants, 1896; Cited by Clements, A. D.: M. J. Australia 2:404, 1946.

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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

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Vol. XXXVI

APRIL, 1950

No. 10

IN THIS ISSUE

Cancer of Skin

Wesley W. Wilson



Congestive Heart Failure

William M. Straight



Observations on Digitoxin

Henry Fuller



Truman's Wonderland

An Editorial



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Volume XXXVI

APRIL, 1950

No. 10

CONTENTS

SCIENTIFIC ARTICLES

Cancer of the Skin in Florida, Wesley W. Wilson, M.D.	619
Current Concepts in the Therapy of Congestive Heart Failure, William M. Straight, M.D.	624
Observations on Digitoxin, Henry Fuller, M.D.	629
Nutritional Appraisal of School Children, Walter Wilkins, M.D.	632
Appendicitis in the Aged: A Report of Five Cases, Ralph Herz, M.D.	634

ABSTRACTS OF MEDICAL ARTICLES

Drs. Leonard G. Rowntree, Elwyn Evans, Ralph Herz, John T. Stage, Jack H. Bowen and John A. Toomey	636
--	-----

EDITORIALS

Dr. Austin Smith	640
Truman's Wonderland	640
The Nineteen Fifties	641
Logic and Democracy Not Incompatible	642

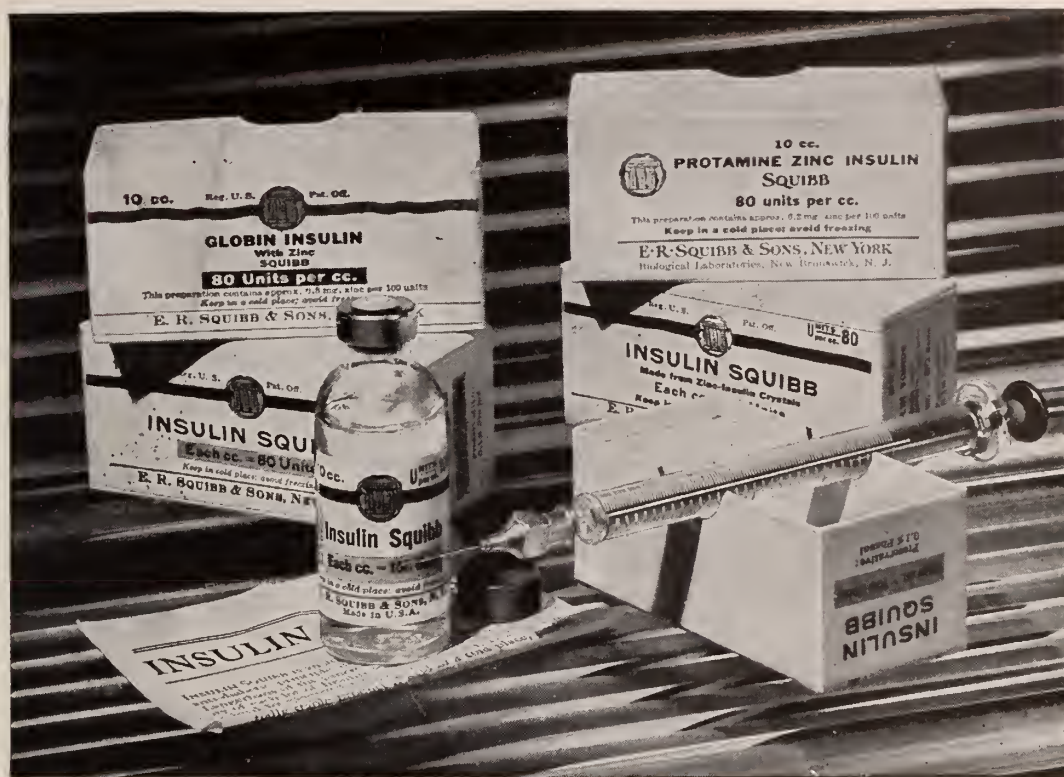
COMMENTARIES

Socialized Medicine Preview	642
Midwinter Seminar in Ophthalmology and Otolaryngology	642
Midwinter Meeting of Florida Society of Ophthalmology and Otolaryngology	643
Intern Association Linked to Reds	643
Seminar on Tuberculosis	644
Revised Duval Monthly Bulletin	644
Pinellas Mail Bag	644
Information Medical Reserve Officers	644
Medical Licenses Granted	645

GENERAL FEATURES

Officers and Committees	638
New Members	646
Your Blue Shield	646
Births and Deaths	647
State News Items	647
Component Society Notes	648
National Education Campaign	649
Obituaries	650
Woman's Auxiliary	656
Books Received	658
Schedule of Meetings	665
List of County Medical Societies, Presidents and Secretaries	666

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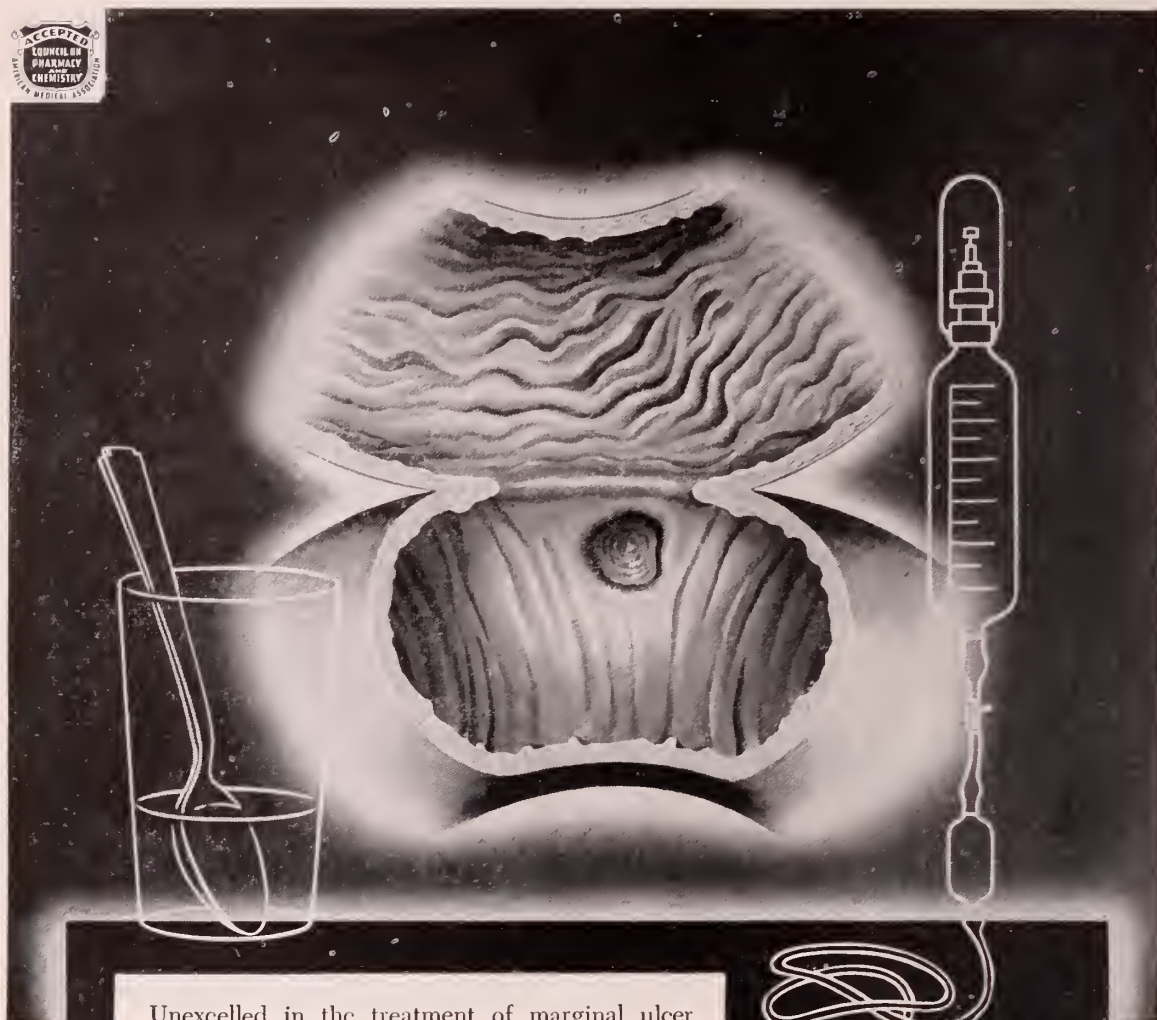
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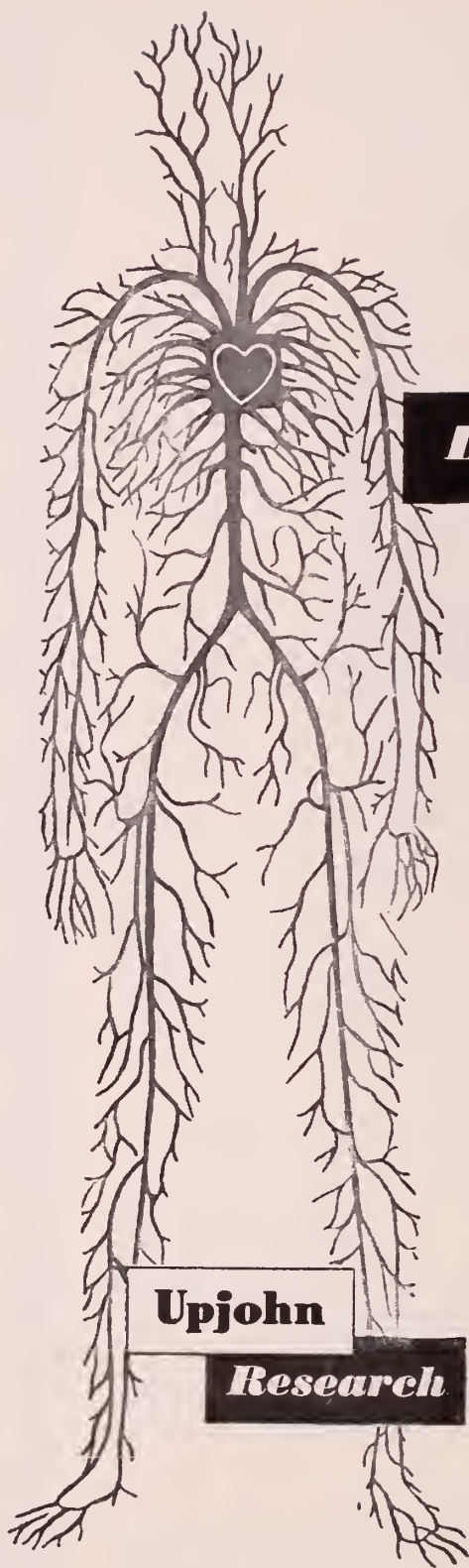
(1) Lyon, R. A.: Am. J. Obst. & Gynec. 47: 532, 1944. (2) Groper, M. J., and Biskind, G. R.: J. Clin. Endocrinol. 2:703, 1942. (3) Wiesbadner, H., and Filler, W.: Am. J. Obst. & Gynec. 51:75, 1946.

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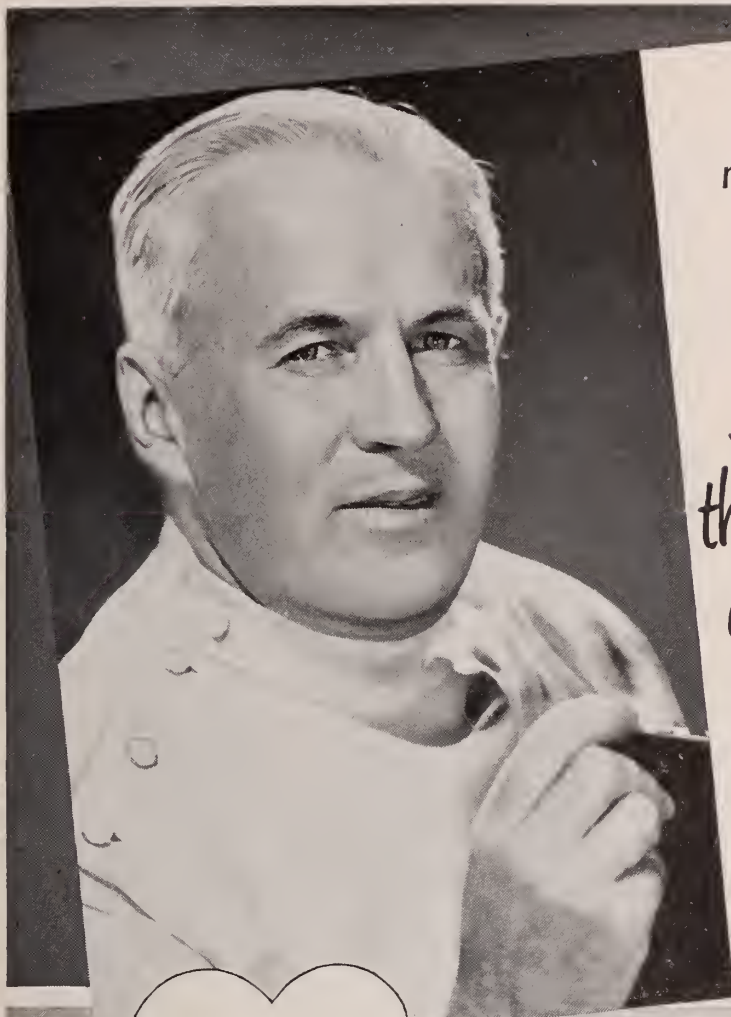
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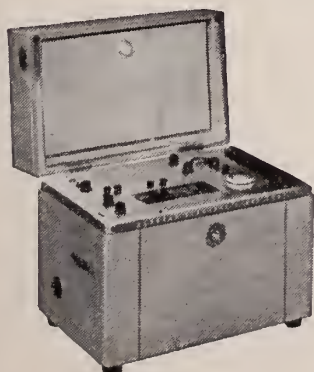
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Cancer of the Skin in Florida

WESLEY W. WILSON, M.D.

TAMPA

Cancer of the skin in Florida communities occurs from three to four times more frequently than in many of the Northern cities of this country (chart 1). Also in Florida, persons with cutaneous cancer usually have several lesions at the same time and sometimes have as many as 40 or 50 lesions during the span of a lifetime.

It is well known that certain types of skin are predisposed to the development of cancer. There is no fact regarding the cause of cancer better established than that habitual overexposure to actinic rays of sunlight on a fair, sensitive skin and maturity are factors that together favor the development of cutaneous cancer. One third of all cancers of the skin occur on the nose, and cancer is common on the rim of the ear. Carcinoma in the Negro skin is uncommon.

In a category similar to that of farmers' and sailors' skin is the cancer which occurs in xeroderma pigmentosum (fig. 1) and in chronic radio-dermatitis. Moreover, the likelihood of cancer is augmented by irritation of warts, moles or so-called precancerous lesions, and also if there is contact, occupationally or otherwise, with arsenic or with pitch, tar, paraffin, lubricating oils or other hydrocarbons containing dibenzanthracene or similar carcinogenic substances.¹

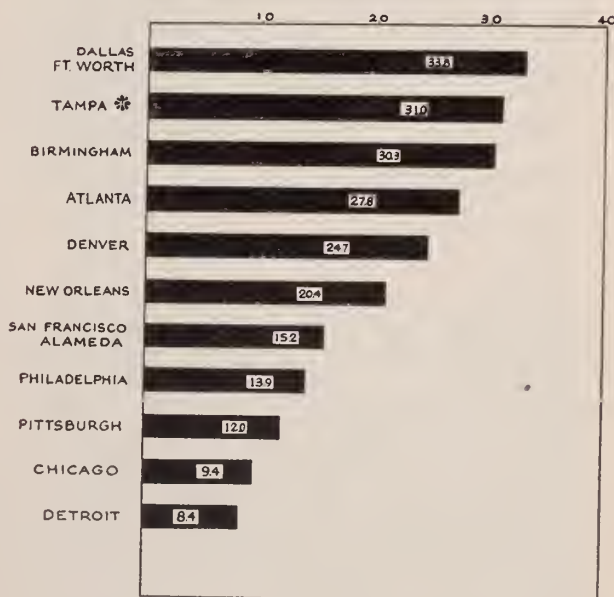
Among occupations in Florida in which skin cancer is relatively common are those of fishermen, farmers (including citrus workers), outdoor laborers (painters, carpenters, construction workers) and turpentine and pitch workers. In addition, cutaneous cancer is common among those engaging in outdoor sports such as bathing, fishing, golfing and boating without adequate protec-

tion. A comparison of the frequency with which cancer of the skin occurred in Florida in 1948 as compared with all types of cancer is given in table 1.

Classification

The commonest malignant neoplasms of the skin arise from the epithelial cells and constitute carcinoma. While there are numerous clinical descriptions and classifications of cutaneous tumors, they are best grouped by the type of cell of which the lesion is composed, and on their histologic basis carcinomas may be divided as follows:²

Chart 1. — Percentage of Cancer of the Skin in Various Cities



*Percentage of all cases of cancer that were cases of skin cancer in Tampa as reported to the Cancer Control Section of the Florida State Board of Health for the period 1948-1949.

Other percentages cover the period 1937-1939.²

- I. Epitheliomas
 1. Basal cell
 2. Intermediate
 3. Mixed
 4. Squamous cell
- II. Melanoma (arising from malignant proliferation of the melanoblasts)



Fig. 1.—*Xeroderma pigmentosum* in a boy aged 11, with carcinoma developing on the right cheek.

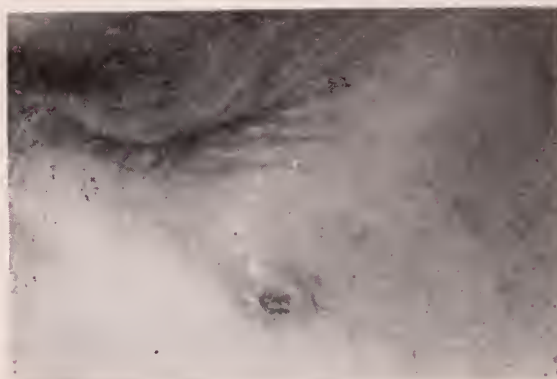


Fig. 2.—Basal cell carcinoma of the left cheek.



Fig. 3.—Senile keratosis of the left eyebrow. Histologic study showed early squamous cell carcinoma.

Basal Cell Carcinoma

Basal cell epitheliomas originate from the epidermis or accessory structures of the skin and usually appear as discrete, pinhead to pea-sized, waxy nodules, which are frequently telangiectatic (fig. 2). The degree of elevation or penetration into the underlying tissue varies considerably. The earliest lesions are like small inverted buttons, slightly elevated above the surface of the skin. A typical history usually reads as follows: The patient noticed the appearance of a small, firm, painless nodule which persisted; later a crust formed which fell off spontaneously only to reform, and the nodule gradually increased in size.

In addition to the button and plaque type of basal cell carcinoma, another type known as the rodent ulcer is sometimes observed. It is a burrowing, mutilating, destructive growth which occurs mostly about the eyes, the ears and the nose.

Table 1.—Cases of Cancer Reported in Florida in 1948*

A. Cases of Cutaneous Cancer and Other Types

SITE	WHITE		NEGRO		TOTAL
	M	F	M	F	
Skin Cancer	140	89	3	5	237
All Others	113	252	53	121	539
Total	253	341	56	126	776

B. Percentage Distribution of Cases in A

SITE	WHITE		NEGRO		TOTAL
	M	F	M	F	
Skin Cancer	55.3	26.1	5.4	4.0	30.5
All Others	44.7	73.9	94.6	96.0	69.5
Total	100.0	100.0	100.0	100.0	100.0

*Cases of cancer reported to the Florida State Board of Health from various tumor clinics in Florida (courtesy of Dr. R. F. Sondag, Director, Bureau of Preventable Diseases, Florida State Board of Health).

In these locations it may cause complete destruction of the orbital contents or of the external ear or nose.

Morphea-like basal cell epitheliomas may, as the name implies, resemble a localized patch of scleroderma. Pigmented basal cell carcinomas appear as the plaque type except that they are a dark brown color; these may be confused by the inexperienced with melanomas.

Intermediate and Mixed Carcinoma

The intermediate and mixed types of carcinoma may appear clinically as pure basal cell epitheliomas. Histologic differentiation from basal cell carcinoma is important inasmuch as the basal-squamous cell epithelioma may metastasize. This group represents about 15 to 20 per cent of the clinically basal cell type.³

Squamous Cell Carcinoma

Squamous cell epithelioma may have the waxy appearance of a basal cell epithelioma, but more often, and more characteristically, the squamous cell type presents a warty, cornified appearance (figs. 3, 4, 5, and 6). The exception to this rule occurs on the mucocutaneous surface where the lesion may begin as a plaque or a small ulceration, usually as an elevated plateau with an indurated base. The squamous cell epithelioma may grow rapidly and present cauliflower-like vegetations from which a foul-smelling, purulent or sanguineous fluid sometimes exudes.

Extension to the regional nodes frequently occurs from lesions on the hands and fingers and in some cases from lesions of the lip. The patient may succumb sooner or later from these metastases.

Melanoma

Malignant melanoma is one of the most dreaded and vicious of all tumors (fig. 7). Foot² stated: "It has perhaps the most sinister reputation among malignant tumors." It is now known that melanoma constitutes malignant proliferation of the melanoblasts. Melanoma may arise from a pre-existing nevus or from a premalignant lesion such as lentigo maligna (a brownish macule showing histologic changes of malignant melanoma in situ). When it arises from a nevus, the patient notices the enlarging of the lesion, which becomes darker in color, sometimes blue-black in appearance. This dark color usually extends beyond the border of the original lesion. Malignant melanoma metastasizes early and rapidly to regional and distant lymph nodes as well as to vital organs. Occasionally, a melanoma may arise from a normal skin, first appearing as a brownish macule, then developing into a darker nodule. Malignant melanomas occur more frequently about the nails (subungual melanotic whitlow of Hutchinson), the feet, face and neck. Malignant melanomas in children less than 10 years of age are less malignant and offer a better prognosis with adequate therapy.

Diagnosis

An accurate diagnosis is essential before proper therapy may be carried out in cancer of the skin. A careful clinical examination with particular at-



Fig. 4.—Squamous cell carcinoma of the tongue arising from syphilitic leukoplakia.



Fig. 5.—Squamous cell carcinoma on the dorsum of the hand arising from senile keratosis.



Fig. 6.—Squamous cell carcinoma on the foot arising in an area of chronic dermatitis.

tention to the depth or extension of the lesion or involvement of the regional nodes should first be made; then, in order to confirm or rule out a clinical impression, a portion of or the entire lesion must be submitted for histologic examination. If lesions are small, or if they do not involve some important structure such as the eyelid, the entire lesion may be removed as a specimen for biopsy. In cases in which melanoma is suspected, the entire lesion must be removed by wide and deep excision. It is highly advisable to obtain a biopsy of all lesions which are removed, even though they arouse no suspicion of malignant disease on clinical inspection, since a certain proportion will be found to be carcinomatous and subsequent therapy may be carried out, if indicated. Often, an alert, well trained dermatologist may detect a cancer of the skin when in reality the patient is consulting him about some other cutaneous ailment located on a different part of the body.



Fig. 7.—Melanoma arising from a brown, flat mole on the skin.

Treatment

Eradication is the object of all types of treatment for cancer of the skin. The method must depend on careful evaluation of the patient, type of lesion, previous treatment and available methods. Frequently it is impossible to compare methods with complete satisfaction because in no two lesions are all the circumstances precisely the same. The practitioner must be guided by the experience of open-minded groups, preferably in well equipped cancer clinics, who are critical of themselves and constantly improving their own methods.⁴

Warren, Simmons and Rea⁵ reported 57 per cent three year cures and 48 per cent five year cures in a group of 829 patients with cancer of the skin diagnosed without biopsy and treated by roentgen rays and radon alone. They stated that 25 per cent of the deaths occurred after primary healing. Primary healing should not be considered as a cure. Warren and Lulenski⁶ noted that 42 per cent of the recurrences developed two or more years after the original healing.

Elliott and Welton⁷ reported the treatment of 1,742 patients with cutaneous cancer; 381 of the diagnoses were confirmed by histologic examination. The combined use of curettage, electrothermal destruction and roentgen ray therapy resulted in 97.1 per cent cures in 1,052 patients followed for a period of five years. Cannon⁸ had similarly good results with this method of treatment in carcinoma of the skin.

Thompson⁹ reported 3.8 per cent recurrence in a series of 1,394 cases in which the patients were treated with desiccation, curettage and roentgen rays.

The results in my cases in which the patients were followed more than three years and the combined methods of electrosurgery and roentgen therapy were used have shown practically no recurrences, although to date I have treated a much smaller group of patients in private practice than Elliott and Welton,⁷ Cannon⁸ or Thompson.⁹

Traub¹⁰ stated that the dermatologist is well qualified from the standpoint of his diagnostic and therapeutic training to treat basal cell carcinoma and early squamous cell carcinoma of the skin. He is not limited to surgical methods as the surgeon is, nor is he limited to radiation therapy only, as is the radiotherapist. He is able to remove and at the same time irradiate cancer of the skin as an office procedure in the ambulatory patient.

Mohs¹¹ reported a chemosurgical treatment of cancer of the skin in which he applies a zinc chloride paste, producing a chemical fixation of the tissues suspected of being cancerous. Location of remaining active cancerous lesions is accomplished by systematic microscopic examination of the excised tissue. If histologic study shows active cancer, that portion of the lesion receives a reapplication of zinc chloride paste until the carcinoma is entirely removed. This is a tedious, time-consuming and sometimes painful procedure; however, it has been found to be successful in certain cases in which surgery and radiotherapeutic measures have failed.

Prevention of Cutaneous Cancer

Fair-skinned persons should try to avoid outdoor occupations and outdoor sports during the middle of the day. The skin may be protected from the ultraviolet rays to some extent by the use of filtering applications such as those containing salol or para-aminobenzoic acid. Physicians and patients should be on constant guard so that precancerous lesions, such as keratoses (from sun, tar, arsenic and pitch), cutaneous horns, leukoplakia, moles which may be irritated or growing, shall be treated promptly. Proper caution should be taken in the use of roentgen rays and radium to avoid radiodermatitis, which is a precancerous disorder.

Thirty years ago a large number of deaths from cancer in the United States were from cancer of the skin. Because of early diagnosis and treatment, now only 6 per cent of all such deaths in this country are from cutaneous cancer. This percentage may be further reduced by the improved treatment and methods of prevention.

Summary

The prevalence of cancer of the skin in Florida is discussed. Modern methods for the diagnosis and treatment of cutaneous cancers are reviewed and evaluated. The method of choice in the treatment of most of these cancers is surgical or electrosurgical removal followed by the use of roentgen or radium therapy. Prevention can best be accomplished by promptness in the treatment of precancerous lesions of the skin.

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Discussion

DR. WILEY M. SAMS, Miami: The essayist is to be commended on the factual presentation of his subject. Illustrations are always of interest, and those which Dr. Wilson has chosen are indicative of his ability as a photographer. The dermatologist has a long-standing, keen and continuing interest in all of the problems associated with cancer of the skin. The first recognition of any cause for cancer was made on those lesions which occurred on the skin. Sir Percival Pott described cutaneous cancer on the scrotum in chimney sweeps, the carcinogenic agent being one of the tars in wood or coal smoke. These cancers produced by oil, arsenic, light, roentgen rays and thermal burns have all been recognized and described by clinicians for many years. Dermatologists have made many contributions to the study of the precanceroses. These may be classified as those which are obligatory, such as Bowen's disease, Paget's disease of the nipple, erythroplasia of the penis, and most of the warty lesions associated with xeroderma pigmentosum. Facultative lesions would include leukoplakia, roentgen dermatitis, senile keratosis, and a good many other conditions which only rarely develop into carcinoma.

There are many interesting facets in the epidemiology of cancer of the skin. Its higher incidence in those climates where the hours of sunshine greatly exceed the average is a well established fact. A somewhat different approach to the problem was offered by studying the incidence of cutaneous cancer in white members of the armed forces during the last war. In those under the age of 35, the incidence in Southern-born troops was almost twice as high as in an equal number of those born above latitude 40 north. In the same study this difference was not nearly so pronounced with the older group above the age of 35. This finding indicates that dermatotropic agents in childhood are more important in changing the distribution of cancer of the skin in a population than is exposure in later life. While mortality statistics of surface cancer, that is, cancer of the skin and lip, occupy an inconspicuous place of not more than 3 or 4 per cent, cancer of the skin and lip accounts for 42 per cent of all cases in a statistical study of incidence of cancer in Navy personnel.

In private practice I find that the problem of cutaneous cancer, actual or suspected, is a factor in nearly 10 per cent of patients in routine practice. In dermatologic cases a diagnosis of cancer of the skin was made on 4.6 per cent of the patients seen in my office. An additional 2.7 per cent had keratoses which, while not malignant, carried a potential threat of subsequent degeneration. Fortunately, the malignant melanoma is relatively infrequent, representing but one case in a hundred. This rate of incidence is considerably lower than is reported in the North and reflects again the increasing incidence of cutaneous cancer in Florida.

Many and long have been the discussions regarding the most desirable method of treatment. The skill and ability of the operator and the type of the lesion will largely determine the choice of treatment. The best method may vary according to that with which the physician is most familiar. Combined treatment has many advocates. Experience and judgment are the background on which each individual case should be weighed. The size of the lesion, its location and type, previous treatment, the age of the patient, his physical condition and his life expectancy must all be considered. Expediency and the cost of care are factors which cannot be overlooked. Plastic repair and restoration of a destroyed ear or nose, while most desirable in selected cases, can neither be offered, nor are they desired, for many patients in the older age group. All of these factors deserve consideration in choosing the method of treatment.

DR. ROGER F. SONDAG, Jacksonville: The skin is the commonest site of malignant lesions, being responsible in 237 (30.5 per cent) of the 776 cases of malignant disease approved for diagnosis and treatment under the State-Aid Cancer Control Program. In all of these cases except 8 the disease occurred in white patients. The skin was the

commonest site in white males, being responsible for 140 of the total, or 60 per cent; it was the second commonest site in white females, being responsible for 89 of the total, or 37 per cent. The incidence of malignant disease in Florida during 1948 nearly approximated that occurring among the patients of tumor clinics in Tennessee. Comparing the experience in Florida with the experience in other areas, one finds that in 30.5 per cent of the total number of cases of malignant disease in Florida during 1948 the lesion was of the skin; in Tennessee, 27.5 per cent; in New York, 11.7 per cent, and in Connecticut, 9.5 per cent. Approximately 80 per cent of the cutaneous lesions in Florida were discovered in the group beyond 45 years of age. It would appear, then, that the actinic

rays of the sun, plus the senile changes which occur in the skin, are predominant factors in malignant disease of the skin. During 1948, there were over 2,900 deaths from cancer, and 70 of these, or 2 per cent were due to lesions of the skin.

Dr. WILSON, concluding: I wish to thank Dr. Sams and Dr. Sondag for their important discussions. It is interesting to note that Dr. Sondag stated that 2 per cent of cancer deaths in Florida were from cancer of the skin. This would seem to indicate that the physician and the patient were on the lookout for cancer of the skin in this state, and I am happy to learn that death from skin cancer occurs only one third as often in Florida as in the entire United States.

Current Concepts in the Therapy of Congestive Heart Failure

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This brief paper is limited to discussion of the therapy of congestive heart failure with a brief resume of those current physiologic concepts necessary to the understanding of the principles of therapy. No attempt at an exhaustive review of the literature is made, though the student wishing to investigate further will find ample material in the bibliography.

Current Concepts

There are two current physiologic concepts of the mechanism of failure, the classical one now referred to as backward failure, which proposes that mechanical inefficiency of the pumping action of the heart initiates failure, and the more recent concept known as forward failure, which holds that sodium retention initiates fluid retention, which in turn increases the plasma volume and thus throws a heavier load on the heart than it can efficiently pump. To some extent the current concepts of therapy are based on both theories; I shall, therefore, review them briefly without entering into a discussion of their correctness.

The frequency of pulmonary edema in early congestive heart failure with the finding of a large, dilated and hypertrophied left ventricle, which is presumably weakened and inefficient, suggests the concept of isolated left ventricular failure being due to weakened chamber walls.¹ According to this concept either ventricle may fail individually, or in sequence, or both may fail simultaneously. Most frequently, however, the left ventricle first

fails to pump into the systemic circulation all of the blood that comes from the lungs, producing pulmonary congestion, which in turn throws a strain on the right ventricle, which then becomes inefficient and produces engorgement of the peripheral veins, hepatomegaly, ascites and peripheral edema. The cause of the ventricular inefficiency may be hypertension, incompetent valves, stenotic valves, myocardial infarction, arrhythmias, prolonged tachycardia or myocardial hypertrophy, so that the blood supply to the muscle fibers of the heart is no longer adequate to supply oxygen and remove wastes, and the fibers thus contract inefficiently.^{2,3} In view of the relative frequency of hypertensive heart disease this last mechanism is thought to be the most frequent cause of cardiac inefficiency.

The forward failure theory as it is expressed today is based on experimental evidence which indicates: (1) an inadequate cardiac output in most instances of failure, (2) a disproportionate decrease in the renal blood flow, as demonstrated by the catheter technic, which does not correlate with the increase in venous pressure but does with the reduction of cardiac output, (3) a consequent impairment of renal function and an increase in sodium retention which in turn cause (4) increase in water retention both within the vessels and in the tissue spaces. It is thought that this theory explains the increase in plasma volume regularly observed in congestive failure and that this increased plasma volume overburdens the myocardium weakened by

the abnormalities mentioned.⁴⁻⁷ Other evidence indicates that increased venous pressure further enhances sodium and water retention by the renal tubules and aids in perpetuating the vicious circle.⁷ Some investigators believe that the antidiuretic hormone from the pituitary⁵ and/or increased adrenal corticoids⁸ may play a role in sodium and water retention.

Treatment

Of first importance in the treatment of acute congestive failure is bed rest. In severely ill cardiac patients exercise causes a decided rise in the venous pressure, and the cardiac output may rise or fall.⁵ Exercise adversely affects the weakened myocardium in three ways: (1) by increasing the cardiac output and thus the load, (2) by increasing the ventricular rate and thus shortening the period allowed for recovery of the muscle fiber, and (3) by increasing the average aortic pressure, that is, the pressure against which the heart must empty.^{9a} In the acute failure, by rest is not meant recumbency for it has been shown that this may be associated with a further fall in the cardiac output. The patient with acute cardiac failure is best kept in a sitting position with the legs dependent and serving as a pool for the edema fluid. This is well accomplished in a comfortable easy chair. As the fluid is eliminated by the kidneys, the legs may be elevated and the head lowered gradually. The degree and duration of restriction of activities is dependent upon the severity of the failure. In severe failure the patient may have to be fed and shaved, and ten to fourteen days of strict bed rest with gradual getting up may be required. In mild failure the patient may be treated while ambulatory with the stipulation that he do no physical work for several days.

The classical drug in the treatment of congestive heart failure is digitalis or one of its glycosides. Its mechanism of action is chiefly on the myocardium: (1) increasing the force of systolic contraction and thus permitting the ventricles to empty more completely, (2) shortening the period occupied by cardiac systole and thus allowing a longer rest period for recovery of the muscle fiber,

and (3) decreasing the oxygen consumption of the muscle fiber probably because of a decrease in the diastolic size of the heart. Digitalis also acts directly and reflexly on the conduction tissue and pacemaker to produce a slowing of the ventricular rate. Most of the recent evidence indicates, however, that the action on the myocardium is the chief cause of the cardiac slowing and of decrease in venous pressure.^{10a} The hypothesis has been advanced that the primary action of digitalis is to reduce venous spasm and thus pool the increased circulatory volume in the venous reservoirs, but most of the evidence fails to support this concept.^{10a, 11}

Infusions and tinctures of digitalis are inconsistent in potency and dosage, and have little to recommend them for routine usage. There remains a choice of the whole leaf digitalis or one of its glycosides, such as digitoxin, digoxin, lanatoside C, or digifolin. At this point it might be well to mention strophanthin and ouabain, which are also cardiac glycosides and useful in congestive failure, though not widely used in this country. It is doubtful if the purified digitalis glycosides are of more value than the whole leaf digitalis for routine use. It is claimed that they cause less local irritation, but local irritation is probably not the cause of vomiting induced by digitalis. Certainly the advantage to be gained by their use is not worth any added cost to the patient. Digifolin, digoxin, digitoxin and lanatoside C have the advantage of being capable of intramuscular or intravenous use. Digoxin is probably the safest of the oral glycosides in that its effect rarely lasts longer than forty-eight hours; thus if toxicity is encountered, it is rapidly corrected by withdrawal of the drug.

The dosage of digitalis must be considered from two aspects: the initial digitalizing dose and the amount required for maintenance. Probably the commonest error in digitalis therapy is the reluctance to give an adequate initial dosage. In table 1 are the average digitalizing and maintenance doses of the various preparations for adults.^{12, 13}

Table 1

Drug	Digitalizing Dose	Daily Maintenance Dose
Whole leaf digitalis*	1.2 Gm. or 17 grains	0.1 Gm. or 1½ grains
Digoxin	1.0 mg. intravenously or 2-3 mg. orally	0.25 to 1.5 mg.
Digitoxin	1.2 mg.	0.15 mg.
Lanatoside C	1.0 mg.	1.0 mg.
Digifolin	3 USP units	

*In children the total digitalizing dose of whole leaf digitalis is approximately 0.15 Gm. per 10 pounds of body

weight, and the daily maintenance dose is 1/10 to 1/15 of the total digitalizing dose.¹¹

It must be emphasized at this point that these are average figures and that each patient is an experiment unto himself and may require more or less than the stated amount. Furthermore, at present there is disagreement as to the digitalizing dose of digitoxin, some workers believing that it should be 2.0 mg. rather than 1.2 mg.¹²⁻¹⁶ In all instances the initial digitalizing dose stated presupposes the patient has received no digitalis for at least three weeks prior to the start of therapy. If the patient has received digitalis within that period of time, the initial dosage must be reduced proportionately. In my experience digitalis leaf, 18 grains, or digitoxin, 1.2 mg., has in general given satisfactory results for initial digitalization. Rarely, especially rapid digitalization may be desirable, and a single intravenous dose of lanatoside C may be used.¹⁷ Usually some such schedule as one half the total amount immediately and one fourth at each of the two succeeding six hour intervals is satisfactory. Full digitalization should usually be accomplished within twenty-four to forty-eight hours, though in mild failure longer periods of time are permissible. When more than forty-eight hours are consumed in the initial digitalization, the daily excretion of digitalis must be considered, and added to the amount required for full digitalization. The amount of the daily excretion of the drugs is the maintenance dose noted. It is no longer thought necessary to push digitalis to toxic levels if the satisfactory therapeutic effects are reached prior to the appearance of toxic manifestations.

Once initial digitalization is accomplished, administration of the maintenance dosage is begun on the following day. Again the figures noted represent averages and considerable variation is to be expected. It will be observed that practically the entire digitalizing dose of lanatoside C is excreted in twenty-four hours; thus if this drug is used for rapid digitalization, one of the more slowly excreted preparations must be given soon afterward for satisfactory maintenance of the digitalization. In general, the desirable dose for maintenance will maintain the patient without evidence of failure and with a ventricular rate between 60 to 80 per minute. Digitalis should be withheld if the ventricular rate at rest falls below 60, or increased cautiously if it exceeds 80.

To use digitalis adequately, one must be on the alert for its toxic manifestations as well as evidence of satisfactory effect. Its chief toxic manifestations

are: bradycardia, nausea, vomiting, diarrhea, yellow vision and electrocardiographic prolongation of the auriculoventricular conduction time. Rarely, digitalis toxicity may cause a tachycardia and various arrhythmias. The injudicious use of large intravenous doses has produced ventricular fibrillation and sudden death.^{10a,18} It has been reported that diarrhea and yellow vision do not occur in the toxicity of the purified glycosides, but this report is not in accord with my experience. The only definite contraindication to the use of digitalis is the presence of severe heart block with the Stokes-Adams syndrome.

The best results from digitalis therapy are to be expected in hypertensive, arteriosclerotic, and rheumatic valvular heart disease. If there is no severe narrowing of the coronary ostiums, syphilitic heart disease will also respond. Heart failure occurring in myxedema, hyperthyroidism, beriberi and acute rheumatic myocarditis responds poorly to digitalis therapy. Prolonged use of maintenance dosage of digitalis has been shown to be of great value in preventing the recurrence of failure.¹⁹

The third important item in the therapy of congestive heart failure is the use of diuretics. The acid-forming salts and the mercurial diuretics are the most widely used today. The mechanism of action of the mercurial diuretics is a specific blocking of the tubular resorption of the sodium ion and water.^{10b,20} This action is thought to be a toxic effect on the renal tubular cells though no histologic changes are seen even in patients who have received prolonged daily medication with the drugs. Because of the probability of this toxic effect, for many years the mercurials have been thought too dangerous to use more often than every four days. In the last several years, however, work by Gold¹² has indicated that these fears may be unjustified. He has used daily injections of 0.5 to 2 cc. for as long as three years with no ill effects. He has also used them in the presence of uremia without disaster. He believes that mercurial diuretics are more important than digitalis in the therapy of congestive failure.

The various mercurials, mercupurin, mercuzanthin, mercuhydrin and salyrgan-theophylline, are equally efficacious though mercuhydrin is somewhat less painful on intramuscular injection. The dosage is 0.5 to 2.0 cc. with an initial injection of not more than 1 cc. The intramuscular route is to

be preferred, though many thousands of injections have been given intravenously. All of the 33 reported fatalities following the use of these drugs occurred when the intravenous route was used.²¹ At present it is thought that one of these drugs should be used daily until the patient ceases to lose weight and the so-called "dry weight" is obtained.¹² The mercurials may also be used orally in doses of 1 tablet once or twice daily after meals, and as suppositories once daily with satisfactory diuresis being obtained in 60 to 70 per cent.²²

The fatalities from mercurials were equally distributed among the various preparations, and 44 per cent occurred during the first three injections. The reaction was of the allergic type, beginning one to three minutes after the injection with cyanosis, pallor, substernal distress, dyspnea, tachycardia and death, presumably in ventricular fibrillation.²¹ If the intravenous route is to be used it would seem wise to administer small doses for the first three injections and to inject slowly. Careful studies have failed to show any difference in the total output following a single injection when the intravenous and intramuscular routes were compared. An occasional side effect of vigorous diuresis is the concentration of the digitalis in the body and the production of digitalis toxicity. The one definite contraindication to the use of mercurials is acute glomerulonephritis with hematuria for they regularly increase the hematuria.

The acid-forming salts such as ammonium chloride are rarely sufficiently potent for use alone in severe acute congestive failure though they may be used to potentiate the mercurials. There is a difference of opinion whether the resulting potentiation is worth the risk of their use.^{12,22} The dosage usually recommended is 3 to 12 Gm. daily in divided doses. Urea has also been used to potentiate the mercurials, but many believe that it is not worth the risk involved. Both the acid-forming salts and urea are dangerous in the presence of renal impairment for they will upset the acid base balance of the blood.

The fourth important item in the therapy of congestive heart failure is the restriction of the sodium intake. This measure has been advocated intermittently for more than twenty years. For many years all severely ill cardiac patients were given immediately a Karell diet, which permits only 800 cc. of milk daily allowing about 400 mg. of sodium daily. Fluid was also restricted to 1,200 cc. daily, and the diet was maintained two to four or more days with good results. More recently

Schemm^{23,24} advocated an acid ash diet low in sodium and allowing unrestricted fluids. Present practice is varied but in general the diet used permits about 600 mg. of sodium daily and unrestricted fluids. In less severe failure, and for maintenance after failure is corrected, a diet allowing 2 to 4 Gm. of salt daily may suffice and be more palatable. The larger part of the sodium in the usual diet is obtained in the form of sodium chloride, added either before, during or after cooking. If no salt is used in cooking or added at the table and no naturally salty food included, an ordinary diet will contain 2 to 4 Gm. of salt daily.²⁵ The chief food sources of sodium are meats such as bacon, ham, dried or corned beef, meat extracts such as bouillon, salt water seafood, eggs, milk, and bread or pastries containing baking powder. In general, a low sodium diet should allow not more than one egg, one glass of milk, two slices of commercial bread and none of the meats mentioned which are high in sodium. Of course the various alkaline stomach remedies which contain sodium must be avoided. For stricter regulation, salt-free bread and butter must be utilized.

With the widespread use of sodium restriction and mercurial diuretics, the sodium depletion syndrome has become more frequent.^{25,26} This syndrome is more likely to occur in elderly hypertensive patients and those with definitely impaired renal function, and is characterized by weakness, lassitude, anorexia, restlessness, mental confusion, hypotension and, terminally, evidence of shock and coma. Characteristically, the blood urea nitrogen rises rapidly, and the blood chlorides fall. The oral administration of 20 to 40 Gm. of salt will rapidly correct this syndrome with the rapid fall in blood urea. The basis of the uremia is as yet undetermined, but it is thought to be a prerenal azotemia. Although salt substitutes which contain lithium chloride have proved harmful and have been banned, there are products on the market which do not contain lithium chloride or sodium and thus are safe as well as effective.^{27,28}

There remain other useful measures which are usually of secondary importance. These are: administration of oxygen, morphine and aminophylline, thoracentesis, paracentesis and venesection. During acute failure cyanosis is a frequent finding and may be specifically combated by the administration of oxygen. The apparatus used will vary with the equipment available and the physician's preference. In most instances an oxygen tent prop-

erly applied seems adequate; however, higher concentrations of oxygen can be administered by the nasal catheter, or by an oxygen mask. Recently Barach advocated the use of a positive pressure oxygen mask which forces the patient to breathe out against pressure and supposedly keeps the serum in the capillaries of the lungs by its opposing pressure. In my experience occasionally striking clearing of rales has occurred with this type of mask. There are, however, some objections to its use.^{20,29}

Small doses of morphine (1/6 to 1/4 grain) may be of invaluable assistance in allaying the apprehension frequently associated with acute failure. The dose should not be large enough to depress respiration and rarely need be repeated more often than twice at four hour intervals.

Aminophylline by intravenous, intramuscular, rectal or oral route is also helpful in relieving the dyspnea. The intravenous route is hazardous, particularly if there is known disease of the coronary arteries, and this route accounts for all of the 6 reported deaths following the use of the drug.³¹ If this route is chosen, the drug must be given slowly. The intramuscular route is safe and satisfactory, but the commonly used solvent produces considerable muscle irritation. Rectal suppositories have been helpful in my experience, but the oral route has given little objective effect. If the oral route is used, large doses must be given, and they often produce nausea and emesis. The usual intravenous, intramuscular and rectal dose is 7½ grains, which can be repeated in four hours.

Thoracentesis is an indispensable adjunct when hydrothorax of any appreciable degree is present, for free fluid in the serous cavities is slowly mobilized by diuretics and serves to embarrass the respiration at times.

Venesection may occasionally be a life-saving measure, particularly in isolated left ventricular failure. This may be carried out by the rapid removal of 500 cc. of blood from any accessible vein or by the bloodless technic, which consists of clamping blood in three of the four extremities by the use of tourniquets. These tourniquets should be placed tight enough to prevent the venous return from the extremity and yet loose enough to permit the inflow of blood through the arteries. The bloodless technic has proved satisfactory and in some ways more rational than bleeding; however, it carries with it the possibility of encouraging phlebothrombosis with its unhappy sequelae. Venesection is much less used today than for-

merly, a situation which some cardiologists believe is unfortunate.³² Certainly it has no place when shock is present, as may occur in congestive failure following an acute coronary thrombosis.

Quinidine has purposely been omitted from this discussion as it rarely has value during congestive heart failure.

Summary

In summary, the treatment of congestive heart failure according to present physiologic concepts seeks to reduce the load on the heart by rest, to improve the myocardial efficiency by the use of digitalis or its glycosides, and to correct the excessive retention of fluid by decreasing the intake of sodium and by enhancing its excretion through the use of a low sodium diet and the mercurial diuretics, respectively. The other measures mentioned are adjunctive though at times indispensable.

Appreciation is expressed to Dr. William C. Blake and Dr. Joseph C. Flynn of Tampa for helpful criticism in the preparation of this paper.

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Observations on Digitoxin

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Digitalis continues to be one of the most widely used drugs. And now digitoxin, one of the glycosides in both digitalis lanata and digitalis purpurea, seems about to supplant the powdered leaf in popularity. Because there appears to be a significant, although slight, difference between the powdered leaf and digitoxin, it seems appropriate at this time to point this out. First of all, I should like to review briefly the signs and symptoms of digitalis intoxication.

By the term digitalis intoxication is meant the unpleasant symptoms occurring from administration of digitalis and the symptoms and signs of overdosage. There is no sharp line to distinguish therapeutic effect from intoxication, and we physicians should remind ourselves that signs ordinarily indicating slight toxicity may often exist in patients securing beneficial results from digitalis. Particularly is this observation true in mild partial auriculoventricular block, which often is present in patients taking digitalis who are doing well and show no other toxic symptoms.

Digitalis intoxication manifests itself by (1) cardiac arrhythmias and (2) certain effects on portions of the body other than the heart. There

is a widespread tendency to think that toxicity caused by digitalis is always accompanied by slowing of the pulse or production of a bigeminal rhythm and that in any case of overdosage one of these arrhythmias will be present. This conclusion is, of course, not warranted. High grade heart block and bigeminal rhythm due to premature beats are indeed both important and common signs of digitalis intoxication, but what seems to be overlooked is that abnormally rapid rates are also signs of serious overdosage. Auricular fibrillation, idioventricular rhythm, ventricular tachycardia, and even ventricular fibrillation may be manifestations of digitalis overdosage.

Aside from the effect on the heart, the chief effects of digitalis are on the gastrointestinal tract and the central nervous system. It has not been proved, but it is likely that digitoxin has less local irritant effect in the stomach than digitalis, possibly none at all.¹ It seems to be certain that both digitalis and digitoxin produce medullary symptoms, chiefly malaise, headache, anorexia, nausea, vomiting, visual disturbances, diarrhea and delirium.

Apparently, digitoxin produces the side effect of nausea to a less degree than digitalis, although Stewart and Newman² did not concur in this conclusion, and the lack of the usual warning signs

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when the patient is on digitoxin demands that the physician be more alert to the possible insidious development of other evidences of toxicity. In order to illustrate various features of digitoxin intoxication, 4 cases are presented.

Report of Cases

Case 1.—A 76 year old house wife was seen at her home on May 5, 1949. She had been ill some two months with dyspnea, orthopnea and edema. She had been digitalized with digitoxin two months previously with 1.2 mg. in twenty-four hours and had continued to take 0.2 mg. daily afterward. At first she had improved, but for a week prior to May 5 she had been bothered with palpitation, loss of appetite, some nausea but no vomiting, and precordial distress.

Examination showed a well developed woman, slightly dyspneic, with a blood pressure of 180 systolic and 110 diastolic and a moderately enlarged heart without murmurs. An electrocardiogram demonstrated left axis deviation, sagging of the S-T segments, and a prolonged P-R interval of .36 sec. (fig. 1, left). Digitalis was omitted for three weeks, and a subsequent electrocardiogram (fig. 1, right) showed some sagging of the S-T segments but a normal P-R interval. This patient has continued to do well on digitalis leaf, 0.85 grains daily.

The patient in this case was getting decided effects from digitoxin with practically no nausea. The drug had been given only in the usually advised doses.

The second case illustrates a similar point.

Case 2.—An 82 year old widow had complained of malaise and dyspnea without orthopnea for some two months. She was digitalized with digitalis leaf without any improvement two months before admission to the hospital, but digitalis was discontinued after two or three weeks because it did not seem to help.

Two days before admission and the day before admission, she was given a total of not more than 1.2 mg. of digitoxin after having had no digitalis for some four or five weeks. The digitoxin was given merely as a trial, apparently because the patient did not seem to be gaining strength. Her condition, however, up until digitoxin was started was fairly good. There was no evidence of congestive cardiac failure, and the chief complaints were weakness, anorexia and insomnia, but the insomnia was not due to dyspnea or pain.

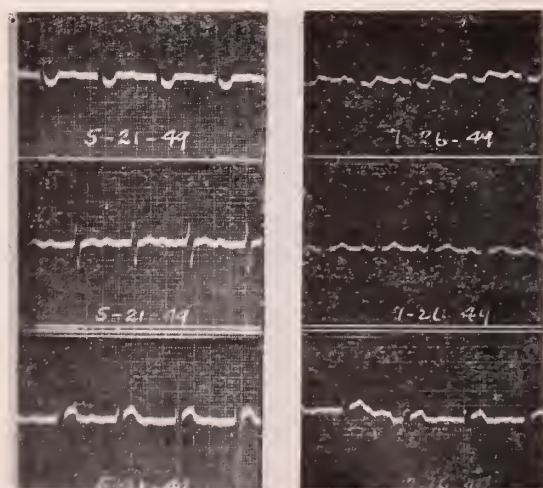


Fig. 1.—Electrocardiograms showing the cumulative effect of digitoxin in a 76 year old woman with hypertensive and arteriosclerotic heart disease.

On the day of admission, May 16, 1949, the patient had become somewhat disoriented and nauseated, her pulse was slow and irregular, and it was feared that she had had a cerebral thrombosis or hemorrhage. On admission, she was an elderly obese woman with a temperature of 99 F. There was pronounced kyphosis of the dorsal spine but no paralysis or edema. There was no conclusive evidence of congestive heart failure although the heart was slightly enlarged. The blood pressure was 140 systolic and 60 diastolic, and there were a few rales at both bases. There was a slight anemia with hemoglobin 10 Gm., red cell count 3.34 million, and white cell count 8,900. The blood urea nitrogen was 19 mg. per hundred cubic centimeters. The most striking feature noted during the examination on admission and for several days thereafter was persistent delirium. The patient was disoriented and uncooperative. Neurologic examinations repeatedly gave negative results otherwise.

An electrocardiogram (fig. 2, left), made two days after admission, showed a regular auricular rate of 130 per minute with a ventricular rate which fluctuated from 80 to 120 per minute and was irregular, with partial auriculoventricular block. Proof that digitoxin was responsible for this phenomenon was that it did not exist before digitoxin was administered and disappeared within eight days of its discontinuance.

The second electrocardiogram (fig. 2, right) was made eight days later. The delirium was believed to have been due to the digitoxin. It disappeared completely when the digitoxin was omitted, and no other cause was found for it. This patient has remained well and has shown no evidence of congestive heart failure during the five months since digitoxin was omitted.

The third case illustrates a more serious effect.

Case 3.—A 70 year old housewife was experiencing severe congestive cardiac failure, probably of several weeks' duration. She had not had medical care previously, although her blood pressure had been taken several months before and she had been told that it was high; however, no treatment had been given.

On examination at her home on Oct. 31, 1948, she was a critically ill woman with dyspnea, orthopnea, and pitting edema of both legs up to the midthighs and sacral region. The blood pressure was 200 systolic and 140 diastolic. The heart was moderately enlarged, and there was a gallop rhythm. No murmurs were heard. The pulse rate was 120 and regular.

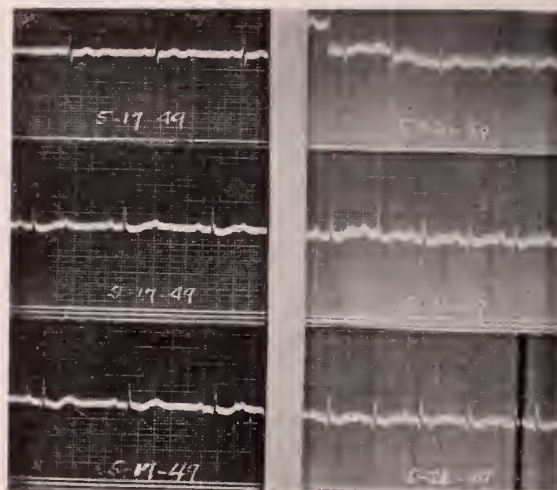


Fig. 2.—These electrocardiograms demonstrate the effect of digitoxin in an 82 year old woman with arteriosclerotic heart disease in whom delirium was apparently produced by digitoxin intoxication.

She refused hospitalization, and plans were made to digitalize her with digitoxin by mouth at home. Later in the day, the patient and her husband decided that she would go to the hospital. She had taken no digitoxin at home.

Digitoxin was given intravenously in doses of 0.4 mg. at 8:45 p.m. and then at 8, lanatoside C 0.8 mg. was given intravenously, and the following morning 0.2 mg. of digitoxin was given intravenously. The pulse rate was now 170.

The first electrocardiogram (fig. 3) was made after the digitoxin was given. Unfortunately, none was made beforehand. The digitoxin was then discontinued, and quinidine was given. In spite of this change and continuous oxygen therapy, the patient died on November 2. Autopsy was not permitted.

The electrocardiogram demonstrates what was probably paroxysmal ventricular tachycardia at a rate of 170. The P waves cannot be positively identified even in a special auricular lead made with the exploring electrode over the auricles. The striking feature of the case is that the patient's pulse became more rapid with digitoxin and lanatoside C therapy than before this was begun.

The fourth case is one of overdosage of digitoxin, but presents some interesting factors.

Case 4.—A 60 year old woman was admitted to the hospital on July 20, 1949, because of palpitation and pain in the chest of five or six days' duration. The thoracic pain was substernal, was not severe, and was not associated with exertion. She had had similar pains for about a year. Her doctor had prescribed digitoxin six days before admission, but the patient had exceeded by far the dosage prescribed and had taken 0.2 mg. three times a day for six days. She had had no nausea, vomiting, visual disturbances or diarrhea.

Examination showed a thin, elderly woman with a temperature of 98.8 F. and an irregular pulse at a rate of 88. The blood pressure was 158 systolic and 90 diastolic. The heart was not enlarged. There were no signs of congestive heart failure.

At the time of admission, an electrocardiogram (fig. 4, left) showed a ventricular rate of 90 and an auricular rate of 120 with frequent dropped beats and a P-R interval that varied from 0.2 to 0.3 sec. Six days later, the partial auriculoventricular block had disappeared (fig. 4, right), but the S-T segments in lead I were still depressed. The patient has done well the past three months without digitalis.

It is interesting that this patient, although she had taken more than twice the usually advised dosage of digitoxin, experienced no nausea or vomiting. There were no toxic symptoms other than the auriculoventricular block.

Discussion

Four cases are few on which to base any discussion. The outstanding features of these cases are:

In case 1, symptoms of toxicity appeared only after the patient had been taking digitoxin for two months. This delay may be assumed to illustrate digitoxin's cumulative effect. The patient had had the usually advised dosage.

In case 2, the delirium and the electrocardiographic changes appeared after the usual digitalizing dose. Both were remarkable and in this case cleared up entirely upon omission of the drug.

In case 3, in my opinion the electrocardiogram indicated ventricular tachycardia, and it is likely that digitoxin had something to do with producing it. This statement is made because the pulse rate jumped from 120 before digitoxin was begun to 170.

The fourth case was one of obvious overdosage, but the striking feature was the absence of nausea.

There are several reports in the recent literature of similar observations. Levine³ reported 7

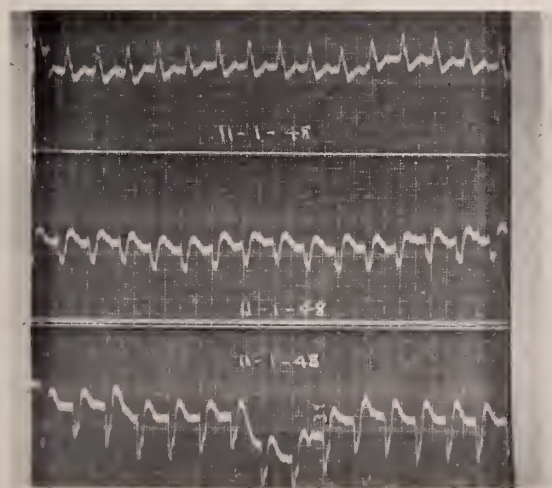


Fig. 3.—Electrocardiogram following administration of digitoxin to a 70 year old woman with hypertensive heart disease and pronounced congestive failure; probable ventricular tachycardia is indicated.

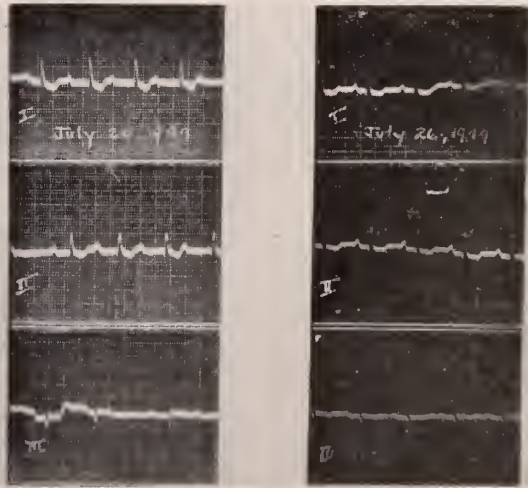


Fig. 4.—Electrocardiograms show effect of overdosage of digitoxin in a 60 year old woman with questionable angina pectoris who had taken 3.6 mg. of digitoxin in six days and had partial auriculoventricular block but no other toxic symptoms.

cases of abnormal rapid rhythms in patients showing toxicity from digitoxin. He believed that with digitoxin these rapid rhythms may develop more insidiously than with the leaf. In 5 of his cases, the abnormal rhythm itself constituted the first and only evidence of toxicity. In his 7 cases, there were 3 instances of paroxysmal ventricular tachycardia, 3 of idioventricular rhythm, and 1 of interference and dissociation. In 3 cases, the dosage of digitoxin was excessive and in 3, it was not excessive. In 1 case, it may have been excessive.

Master¹ commented on the fact that digitoxin has practically replaced digitalis U.S.P.; that the dangerous aspects of digitoxin administration have been disregarded; and that intoxication from it has been frequent. He emphasized the point that clinical observations confirm the pharmacologic fact that digitoxin has the greatest cumulative action (slower dissipation) of all the glycosides. This author stated that the dosage of 1.2 mg. as a single digitalizing dose and of 0.2 mg. daily for maintenance has often been applied indiscriminately to patients regardless of weight and without proper surveillance. "It must be remembered that the daily maintenance dose of digitoxin varies from 0.05 mg. to 0.2 mg."

DeGraff, Batterman, and Rose² concluded that digitoxin offers no particular advantage over digitalis leaf for the routine treatment of the patient with congestive heart failure. "Because of its slower dissipation and the possibility of prolonged and severe toxicity, digitoxin is not, in our opinion, the glycoside of choice."

Stewart and Newman³ believed that 0.2 mg. daily of digitoxin is too much for most patients who have been adequately digitalized, and they concluded it is more difficult to keep patients in equilibrium by a maintenance dose of digitoxin than with the whole leaf.

Conclusion

For rapid digitalization, digitoxin may be used. Its slowness of dissipation, however, makes its use here somewhat dangerous. Digoxin, because of its rapidity of dissipation, probably is a better drug for rapid digitalization. Rapid digitalization, it is worth repeating, is always fraught with some danger.

For maintenance of digitalization, digitoxin appears to have no advantage over digitalis leaf and is more expensive. Because of its cumulative action and the insidious manner in which its toxic symptoms may manifest themselves, a patient receiving digitoxin must be kept under closer observation than one taking digitalis.

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Box 1021.

Nutritional Appraisal of School Children

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How many school children in Florida are suffering from malnutrition? What types? Which ones? How serious is it? Every person who is interested in the health of a group of children would like to have such information.

When is a child malnourished? Is it only when he is actually starving, is it when he fails to reach an optimal nutritional state, or is it some-

where between these two extremes? Such questions are important. One hears widely divergent statements as to the prevalence of malnutrition among school children. Very probably, there are all levels of nutritional status in the school population of Florida.

School children offer an ideal opportunity for public health nutrition work. They (1) are already organized into groups, (2) reflect community conditions, (3) are easily accessible, (4) can be observed over periods of time, (5) are teach-

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able, (6) have plastic habits, (7) reflect changes quickly and (8) are available and organized for follow-up study.

The community looks to the health department for collecting, correlating, studying, interpreting and dispensing information concerning the kind, extent, severity and prevalence of the problems of nutrition. In working with any group of children, one must be armed with such facts before he can make an effective attack on their nutritional problems.

A few of the means by which such facts might be obtained are discussed below:

1. HISTORY.—If any history is taken and recorded on a school health card, could it include questions concerning the current condition of the child, as well as a record of his inoculations and communicable diseases? Could it be concerned with factors which might be remediable at present? Could it be made more current and dynamic and less perfunctory and static? Certain information concerning nutrition can be obtained on a group basis, especially when the individuals of the group have problems in common. Remedial measures will be chiefly educational in nature.

2. PHYSICAL EXAMINATION.—If a physical examination is made, could it include a brief search for signs that suggest malnutrition; for example, appearance of chronic fatigue, bad posture, pallor, rough skin, spongy bleeding gums, red tongue, crusty eyelids, photophobia, sores at the angles of the mouth?

3. LABORATORY PROCEDURES.—At present few health departments are equipped or staffed to carry out extensive laboratory procedures for the evaluation of nutrition. The hemoglobin test, however, is practical for use on school children. A team of three or four persons can make 300 to 400 such tests at the school during the school day. The studies of hemoglobin levels made among Florida school children indicate that anemia is particularly common. It should be remembered that a child can have anemia-producing parasitic diseases superimposed on a state of chronic malnutrition.

4. DIET RECORDS.—Diet records can be of great value in nutritional appraisal of groups. In some classes, the pupils keep records of all food eaten for one, two, or three days, or a week. Large numbers of such brief records, when analyzed and compiled, give a fair picture of the food pattern of the group for the time during which the records are kept. This procedure works well with school children. Many think that this is an excellent educational experience as well as a helpful fact-finding device.

5. THERAPEUTIC TESTS.—Since a number of nutrients are now available in pure form or as concentrates, therapeutic tests are taking on greater practical significance. Foods may also be used in therapeutic testing. It would seem that the therapeutic test could be used much more widely as a fact-finding procedure. It should be recognized as a part of a diagnostic procedure and should not be considered as therapy.

Any facts brought to light by such procedures as those mentioned can serve as guides in developing preventive and corrective plans which are educationally sound. Such facts are basic to any rational nutritional program in much the same way that diagnosis is basic to treatment in the ordinary sense.

One must look to agriculture for an adequate supply of the foods which provide essential nutrients. One must look to organized education to help stimulate in the child a desire to do those things necessary for good nutrition. Only the health departments can get the basic facts about the health status of a large group of school children as affected by the food they eat. One must look to them to collect, correlate, study and interpret data, and to furnish information concerning the types, extent, severity and distribution of malnutrition. Then parents, teachers, doctors, dentists, nurses, nutritionists, agricultural workers and others can attack the various aspects of the nutrition problem much more effectively, with far larger forces, and on a much wider front.

Box 210.

Seventy-Sixth Annual Convention
Florida Medical Association
Hollywood, April 23-26, 1950

tines were separated from the pelvic wall. The intestines were viable. This wound was closed, and a right gridiron incision was made. A fecal concretion about 1 cm. in diameter was found free in the abdominal cavity. The appendix was gangrenous and so adherent to adjacent structures that it could not be freed by manipulation. The base was divided; the stump and cut surface were treated with phenol and alcohol. The appendix was then dissected free by clamping and cutting the mesoappendix and dense adhesions. Sulfathiazole powder was applied to the sutured mesoappendix, and the wound was closed in layers.

The patient's condition after the operation was extremely poor, and supportive measures, including blood transfusion, administration of penicillin and streptomycin, were diligently applied. Signs of obstruction persisted until the twelfth postoperative day. Because of the generalized peritonitis, peristaltic stimulants were not administered in the first postoperative days. A glucoside of senna was later given. Recovery was slow but complete, and the patient was discharged from the hospital on the twentieth day after operation (fig. 3).

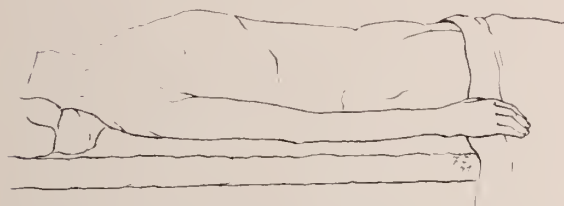


Fig. 3.—Drawing of the abdomen at the time the patient was discharged from the hospital.

Case 2.—A man, aged 74 years, was seen on May 8, 1949. He had had abdominal cramps for two days and had taken numerous cathartics and enemas. There was no vomiting. His temperature was 98.0 F.; pulse rate, 80; respiration, 22; and blood pressure, 140 systolic, 80 diastolic. The abdomen was pendulous and soft, and no masses were palpable. In the lower right quadrant there was pronounced rebound tenderness. Urinalysis revealed no abnormality. The leukocyte count was 17,000, and the hemoglobin was 96 per cent.

A diagnosis of acute appendicitis and regional peritonitis was made. Operation was carried out promptly and revealed a markedly inflamed appendix which was situated retroceally. The cecum was bound down by dense adhesions and was inflamed, distended and friable. It could not be delivered into the wound. The mesoappendix was swollen to four times its normal size. It was clamped in sections, divided and sutured. The appendix was doubly ligated at its base and divided; the stump was treated with phenol and alcohol and fixed into the lowermost suture of the mesoappendix. The incision was closed in layers.

The postoperative course was stormy, despite the administration of antibiotics and sulfonamides, injections of intravenous fluids and early ambulation. Water balance, electrolytes and plasma proteins were carefully maintained, and the peritonitis was brought under control on the seventh postoperative day. A glucoside of senna administered on the eighth postoperative day re-established normal evacuation. All symptoms had disappeared by the eleventh day, when the patient was discharged.

Case 3.—A physician, aged 59 years, complained of pain in the right side of the abdomen. There was rebound tenderness in the right lower quadrant. The temperature was 99 F.; pulse rate, 74; and respiration, 22. Analysis of the urine showed nothing abnormal. The leukocyte count was 13,000. The following day, May 13, 1949, there was no improvement; the symptoms and signs were essen-

tially the same. A diagnosis of appendicitis was made, and appendectomy was performed the next day, two days after appearance of abdominal pain. Pathologic examination revealed an acutely inflamed appendix.

The patient made an uneventful recovery and was discharged from the hospital on the fifth postoperative day.

Case 4.—Mrs. S. E., aged 81 years, was admitted to the hospital on Dec. 10, 1949. There was a history of nausea, vomiting and abdominal pain of two weeks' duration with progressive enlargement of the abdomen.

The patient was a very thin although not emaciated aged woman in no acute distress. No abnormalities of the heart were noted, except occasional extra systole. The lungs were clear. The abdomen was moderately distended, with visible peristaltic waves. High-pitched borborygmus was heard with the stethoscope. No masses were palpable. A tympanic note on percussion throughout the abdomen and questionable dullness in the flanks shifting with change in position were noted. The temperature was 99.5 F.; pulse rate, 108; respiration, 20; red blood cells, 3,800,000; white blood cells, 5,750; hemoglobin, 78 per cent; urinalysis alkaline, albumin 1 plus and sugar negative. A scout film showed multiple dilated segments of small intestine with fluid levels indicative of ileus due to organic obstruction. A working diagnosis of (1) obstipation, (2) intestinal obstruction and (3) appendicitis was made by Dr. Allen S. Shepard.

On December 14 an exploratory laparotomy was performed by Dr. Joseph L. G. Lester, Jr. A large amount of purulent fluid was encountered, and a perforated gangrenous appendix was removed. After a stormy postoperative course, the patient recovered and left the hospital on December 30.

Case 5.—Mrs. M. E., aged 81 years, was admitted to Monroe County Hospital on Jan. 8, 1950. There was a history of pain in the abdomen.

The only significant physical sign was rebound tenderness in the right lower quadrant of the abdomen. The temperature was 100 F. The white blood cell count was 11,000 at 2 p.m. and 14,000 at 8 p.m.

A diagnosis of appendicitis was made by Dr. Allen S. Shepard, and I operated upon the patient at 10 p.m. A moderately inflamed appendix was found with the distal end enlarged. The patient made an uneventful recovery.

Comment

The first 2 cases here reported illustrate that appendicitis may be a cause of serious illness in patients over 70 years of age. In both instances, the operation was not performed until the condition had advanced and peritonitis was present, and hence the postoperative course was prolonged and stormy. The degenerative changes of age of course add greatly to the risk of appendectomy in such patients, and vigorous supportive measures need to be administered. The contrast of these 2 cases with case 3 is striking. In this instance, operation was performed while the inflammation was relatively mild, the patient was much younger, though still beyond the age in which appendicitis is normally expected, and recovery was entirely uneventful. Cases 4 and 5 also illustrate the importance of considering appendicitis in the differential diagnosis of disease in the aged.*

* Cases 4 and 5 have been added since the paper was presented. Appreciation is expressed to Dr. Allen S. Shepard and Dr. Joseph L. G. Lester, Jr., of Key West for permission to include case 4 in this series.

Conclusion

The greatest threat from appendicitis in the aged is not the risk of operation but the failure to make the diagnosis. It is true that in the majority of cases intestinal obstruction in aged patients is due to neoplasms or diverticulitis. But if the pa-

tient still has his appendix, appendicitis must be considered in the differential diagnosis, even though the symptoms are not characteristic of this condition as seen in younger patients. Five illustrative cases are presented.

420 Simonton Street.

ABSTRACTS OF MEDICAL ARTICLES

SOME COMMENTS ON PORTAL CIRRHOSIS. By L. G. Rowntree, M.D. South. M. J. 42:282-289 (April) 1949.

In this general review of cirrhosis of the liver the author designates the subject a particularly live one, packed with problems, many of them as yet unsolved. This disease occurs commonly in this country, most frequently in men in the middle and later years of life, and is usually ascribed to chronic alcoholism, or to syphilis and its treatment. The trend of crude death rates since 1900 is cited. Cirrhosis is defined as the liver's response to toxic agents, whether they be parasitic (schistosomiasis, malaria, amebiasis, syphilis), or chemicals such as alcohol, cincophen, carbon tetrachloride, arsenic, copper, phosphorus, chloroform, or thyrotoxicosis. Pathology, diagnosis and differential diagnosis are discussed.

The various liver functional tests are listed under appropriate headings, and it is advised that their limitations as well as their value be kept constantly in mind. In this connection, the following are regarded as of great importance: (1) the enormous reserve of the liver (80 to 90 per cent may be sacrificed without danger to life); (2) the regenerative capacity of the liver, which is almost unbelievable in degree; (3) the multiplicity of functions of the liver; (4) the participation of the liver in many vital processes; and (5) the changing functional picture incident to the progression of the disease.

Older methods of treatment are reviewed, and the recent work of Patek, which has revolutionized many of the ideas relative to cirrhosis, its treatment and its prognosis is discussed. Impressed with the coexisting malnutrition, Patek came to the conclusion that advanced portal cirrhosis represents a deficiency disease. In consequence, he employed a much more liberal diet and

also administered vitamin B, or its products, brewer's yeast, injections of liver products, thiamine, and so on. Surgery and shunting operations in the control of portal hypertension are also discussed.

Dr. Rowntree concluded: "My impression, based on 35 years of interest in the subject, is that we have failed, and are still failing, to a large degree in our management of cirrhosis of the liver. Prevention, if feasible, will prove our best approach. This, of course, calls for a clear understanding of etiology. Failing prevention, then we should strive for earlier recognition of cirrhosis, and place much greater emphasis on its early management, and on measures to prevent progression, the development of connective tissue, and of fibrosis. We should, if possible, adopt protective management against connective tissue increase, contraction, portal hypertension, and hemorrhage and ascites. Once we are satisfied that our medical management is unsatisfactory, we should call for the surgeon, and see what he has to offer."



CAROTID SINUS SYNCOPE, ASSOCIATED WITH THE NEUROVASCULAR SYNDROME SIMULATING SERIOUS DISEASES OF THE NERVOUS SYSTEM. By Elwyn Evans, M.D. J. A. M. A. 139:226-227 (Jan. 22) 1949.

In many cases carotid sinus syncope remains unrecognized, and the neurovascular syndrome, another frequent though less widely known and only comparatively recently recognized syndrome, is rarely diagnosed. A case is therefore reported in which both syndromes were present, simulating serious disease of the nervous system. Because of the frequency of both syndromes, it is not surprising, the author observes, that the two may occasionally coexist in the same patient.

In the case described, during induced attacks syncope was associated with bradycardia on two occasions, but appeared without appreciable slowing of the pulse on another; the vagal type predominated two times, and the cerebral type the other time. During periods when the patient had syncope or other symptoms referable to the carotid sinus, he was under nervous strain and emotionally upset. Symptoms were made worse by frustration and by several serious diagnoses. The author mentioned having previously noted a definite relationship between various nervous states and carotid sinus sensitivity of the vagal type. The right carotid sinus was not only more dilated than the left, but was also more sensitive. The patient not only showed sclerosis of the carotid sinus, especially the right, but generally. He also complained of angina on effort, associated cardiovascular defects being common in such cases.

The neurovascular symptoms of tingling and numbness of the right third, fourth and fifth fingers, and weakness of the arm disappeared when the patient slept without abducting the arms. They were not attributed to the hypersensitive carotid sinus because they were definitely affected by abduction of the arm, which also obliterated or greatly reduced the radial pulse. Too, the right carotid sinus was by far the more sensitive, and the neurologic reactions to carotid sinus stimulation, including hemiplegia, have been contralateral.

SCIATICA CAUSED BY CYST FORMATION IN OLD HEMATOMA. By Ralph Herz, M.D. Surgery 24:714-718 (Oct.) 1948.

Three cases are reported in which the patients, all women, consulted the author because of severe back pain owing to fascial fat hernias, but had, in addition, unusual manifestations of sciatica which could not be attributed to the fascial fat herniations causing the more generalized back pain. In all 3, the pain radiated down the leg and was more severe when the patient was sitting; one patient also complained of discomfort on walking and displayed an abnormal gait. The sciatic symptoms in all these cases were apparently initiated by trauma, and in all 3, removal of a fibrous cyst in the region of the sciatic nerve relieved the severe, radiating, sciatic pain. It is suggested that these findings may be significant in certain cases of sciatica in which other causes of pain have been eliminated.

In 33 per cent of the cases in which well patients were examined, there was a fluctuation, varying from 1 to 3 Kahn units, in the quantitative titer after the achievement of negativity. A characteristic feature was the return to permanent negativity within two months. Paralleling this fluctuation in titer in the well group, 30 per cent of the relapsed group attained temporary negativity. This drop to negativity was usually sharp, and then, within two months, the titer was again high or was increasing steadily.

It is concluded that in cases of the penicillin treatment of syphilis complicating pregnancy, the quantitative serologic titer serves one of its most valuable roles. A monthly or bimonthly quantitative test on the newborn will indicate whether the positive reaction of the cord blood, or the serologic titer at birth, was due to an active syphilitic infection or was attributable to the transfer of maternal reagins through the placenta to the fetal circulation. It is also concluded that a single negative serologic titer during the early months of follow-up observation is not of great prognostic significance.

CARDIAC ARREST UNDER ANESTHESIA. By John T. Stage, M.D., South. M. J. 42:597-603 (July) 1949.

The purpose of this paper is to present 3 cases of cardiac arrest, 1 in detail, and to outline the belief of the author as to the possible mechanism and active treatment of this catastrophe, which is probably the most dramatic and most sudden of all the emergencies the anesthetist must face. He discusses the problem of cardiac arrest under anesthesia under the headings of (a) nervous control of the heart, (b) anesthetic agents, (c) vasopressor agents, (d) mechanical stimuli, and (e) treatment of cardiac arrhythmias and cardiac arrest.

Dr. Stage's conclusions are: The anesthesiologist and surgeon should organize a plan of attack in an attempt to solve this problem. The anesthesiologist is responsible for the diagnosis. Instruments for entering the chest and sterile syringe and needle setups with the proper mixture of drugs should be ready and available at a moment's notice. Endotracheal equipment should be at the anesthesiologist's side during all operations. Oxygen is supplied by the anesthesia machine. Only by organization, prompt diagnosis and action can we hope to solve this problem adequately.

QUANTITATIVE SEROLOGIC TITER IN POST-TREATMENT OBSERVATION OF EARLY SYPHILIS TREATED WITH PENICILLIN. By Milton H. Gustafson, M.D. and Jack H. Bowen, M.D. Arch. Dermat. & Syph. 59:303-307 (March) 1949.

A series of 117 cases of early syphilis was studied solely for the quantitative serologic response to penicillin therapy. In 71 of these cases the patient became seronegative and clinically well by the end of one year; in 46 cases the patient had either a serologic or a seroclinical relapse. In the former group, the serologic titer became negative in 56 per cent within three months and in 91 per cent within six months after treatment. In the latter group, relapse occurred in 69 per cent within six months and in 80 per cent within nine months after treatment; several months prior to the relapse, a gradually increasing or sustained high titer was observed in every case, thus forecasting the ultimate relapse.

MEASUREMENT OF SENSATION. I. VIBRATORY SENSATION. By John A. Toomey, M.D., Leona Kopecny, B.S., and Sally Mickey, B.A., with the assistance of Paul M. Kohn, M.D., and Helen Reisman, B.A. Arch. Neurol. & Psychiat. 61:663-671 (June) 1949.

In this paper, the first of a series on sensation and its measurement, the authors describe a series of tests in which the phenomenon of vibratory sensitivity (pallesthesia) was studied with a pallesthesiometer called the biosthesiometer. The purpose was to determine whether nonopiate analgesics would have any effect on the thresholds of vibratory sensitivity. Of 123 subjects tested in this series, 81, or 66 per cent, had positive reactions; 16, or 12 per cent, reversals, and 26, or 21 per cent, normal responses.

It is concluded that the biosthesiometer measures the threshold for appreciation of vibration, and also that acetylsalicylic acid raises the threshold for appreciation of vibration in 66 per cent of the subjects tested.

See your March Journal
for the complete
Convention Program

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NOTICE

Your March Journal carried a complete program and other detailed information relative to the Seventy-Sixth Annual Meeting of the Association in Hollywood, April 23-26.

Dr. Austin Smith

In November, editors of The Journal enjoyed a trip to Chicago and while there, they attended the annual meeting of the editors of state medical journals. At that time they had the opportunity to meet Dr. Austin Smith, who was then serving as assistant editor and has since been appointed editor of the Journal of the American Medical Association. Dr. Smith has an excellent background of training and experience which has particularly fitted him for this position. As an undergraduate student he was associated actively with teaching and research and after graduation took additional training in clinical medicine and research. He has held teaching positions at three medical schools and he still holds the title of Professorial Lecturer in the Department of Pharmacology at the University of Chicago. He is a graduate of Queen's University Faculty of Medicine, Kingston, Ontario, Canada and he holds the graduate and postgraduate degrees of M.D., C.M. and M.Sc. (Med.).

Dr. Smith has been associated with the headquarters office of the American Medical Association since February 1940 and as an active participant on administrative committees has met and

helped solve many of the problems which have confronted that association during this period. From February 1949 until December 1, Dr. Smith served as assistant editor of the Journal of the American Medical Association in preparation for his present assignment. He has become well known as a writer, having published several books and many articles on medical subjects. As a speaker, especially before groups raising funds for research, he has been in demand.

Quiet, friendly and efficient, Dr. Smith impresses one most favorably at the first meeting. He seems never to be too busy to greet visitors and friends, and it is obvious that he is capable of performing a large amount of work without seeming effort. The Journal greets the new editor, congratulates him on promotion to this important new assignment and congratulates the American Medical Association on having obtained such an outstanding physician for this post.

Truman's Wonderland

We recently have had the opportunity to read "Truman's Wonderland," which appeared as an editorial in the Jackson (Miss.) Daily News and was entered in the Congressional Record (Appendix A1979) on March 31, 1949.

This fairy story about a kind, generous king of fabulous wealth, who lived in a gleaming white castle surrounded by marble palaces and who wanted to share his wealth with the people, puts across with a punch several points which people need to see, yet apparently cannot see unless pre-

sented in dramatic form:

"One day the king summoned his counselors and addressed them as follows: 'My heart bleeds for my people, . . . So I shall share my treasure with my people. Let all of them come to my storehouse and each help himself according to his wants.'

"The next day the king went to his storehouse and found it bare. Again he summoned his counselors and spoke thus: 'So that I may continue to minister to the needs of my people, it will be necessary to replenish my storehouse, . . . Therefore, I have decided that all my subjects shall be taxed, each according to his means. . . .'

"And so the tax collectors went forth and came to the houses of the people and demanded payment. And they gathered up the gold and silver and precious stones the people had taken from the king's storehouse, save that the poor were permitted to keep a small part of the king's bounty, while from the rich they took in addition their household goods and other possessions until they had left only as much as the poor.

"The tax collectors kept some of the treasure themselves since, not being producers of wealth, they had no other source of livelihood, and gave the rest to the king. Soon the storehouse was full of treasure again, and the king was pleased, saying: 'Have I not dealt fairly with my people?'

"Some of the people were pleased and some were not. The poor said: 'Why should we work any more? The king will take care of us.' The rich said: 'Why should we work any more when the king takes away from us the wealth we produce?'

"And so the people worked less and produced less, and every time after that when the tax collectors came among them there was less wealth to divide. Instead of everybody getting more, everybody got less. But the tax collectors were happy, because they always got their share, and the king was happy because his storehouse was always replenished. 'I have given everybody a fair deal,' the king said."

The Nineteen Fifties

At midcentury the Florida Medical Association is holding its seventy-sixth annual meeting in the familiar setting of Hollywood in a section of the state that has come from practical oblivion to win international fame as a resort area since the turn of the century. Some of us remember how the whistles blew and the bells rang out to herald the birth of this twentieth century.

Life was rather simple at the beginning of the new century. No one was bothered with automobiles, airplanes, radio and television, nor even electric appliances within the home. True enough, the Curies had discovered radium, providing the key to the knowledge of the behavior of the atom, which, in turn, brought atomic fission; but as yet there was no atom bomb with its incalculable potentialities in war and in peace. There was, however, a simple faith in God and country.

Two decades passed, and we had made the world safe for democracy by winning a world war. Security from bank failures was assured by the Federal Reserve Act. Giving women political freedom guaranteed the purity of American politics.

It was in the golden twenties that everyone wore a silk shirt. Poverty had vanished. But free enterprise was not so free as to refrain from criticizing Henry Ford for paying laborers \$5 a day.

The dire thirties with their bank failures, bread lines and apple sellers brought widespread unemployment. In America the paternal state was born.

We fought and won a second world war in the forties. But, somehow, victory failed to win the peace.

It has been well said that "during the twenties we put our faith in self; during the thirties we put our faith in the state; in the forties we put our faith in science and gold."

And now the fifties are upon us. What do they hold for weal or woe? Will there evolve in this sixth decade of the twentieth century a true family of nations that will bring real peace in our day? Will our nation, our democracy, be preserved to us? Will faith dominate, or fear?

There are today in this country some 32,000,000 children under 12 years of age. During these fateful fifties they will be won either by the traditions of freedom that are the foundation stone of true Americanism or by the philosophies of socialism and communism. The next ten years bid fair to determine the destiny of America, of democracy.

The doctor has an enviable opportunity to share in shaping that destiny in the right direction. The social planners who would force upon the nation the welfare state are already knocking hard upon his door, and he is rising up to thwart their sinister designs. What will be his record of achievement when the eighty-sixth session of the Association is held in 1960?

Logic and Democracy Not Incompatible

When the 1949 Taft-Smith-Donnell bill (S. 1581) was introduced, there was a sanctimonious chorus of protest by various labor leaders and politicians, our own Senator Pepper included of course. They based their opposition upon the fact that it proposed subsidizing prepayment medical insurance by the government only for those unable to pay for their own insurance by themselves. The advocates of placing everybody under the yoke and servitude of compulsory government control of medical care call the T-S-D proposition "subsidized pauperism" and blame it for "condoning a degrading means test."

Apart from the ridiculous exaggeration contained in these demagogic statements, where is their logic?

Where is the shame in a person declaring — to the proper authorities — that his income is above or below so much per year? Do we not all have to make such statements to the Bureau of Internal Revenue every year and to the Bureau of the Census every ten years?

Have not the same self-appointed defenders of a mistaken concept of human dignity sponsored identical requirements for beneficiaries of public housing projects? It is a well known and logically accepted fact that persons or families with incomes above certain stipulated levels may not become tenants in such government-sponsored rental units. In fact, an increase in salary may mean an automatic eviction to the worker and his family if the raise brings their income just above the limit set by law. Many a worker living in these housing units has rejected a promotion which would lower rather than raise the standard of living of his family by forcing him to find quarters elsewhere in times of acute housing shortages.

Has anybody ever objected to enjoying good housing accommodations at low cost, fearing it might mark him as a "pauper?"

Socialized Medicine Preview

The chronologic history of a Federal Employees' Compensation case as experienced by a member of the Board of Trustees of the American Medical Association is recounted here for what it portends.

July 26.—The doctor requested authorization to operate for bilateral hernia of occupational origin.

September 10.—A reply was received asking for a report on form CA-32.

September 14.—The report was mailed.

November 5.—An order was issued authorizing operation for hernia on the left side only.

November 10.—The doctor again requested authority to perform a bilateral operation.

December 31.—Another letter was sent by the doctor to the government bureau as a tracer to the letter of November 10.

January 27.—A letter from the bureau stated that the request was quite unusual as one hernia is of long duration, but the claim was being referred for decision.

February 8.—Authorization was granted to operate for hernia on the left side, the bureau stating that it did not object to having the hernia on the right side repaired at no expense to the government, et cetera.

"Ho, hum," commented our informant, "and no doubt the doctor expected the check in his Christmas mail — next Christmas, that is."

Midwinter Seminar in Ophthalmology and Otolaryngology

The popular Midwinter Seminar in Ophthalmology and Otolaryngology, sponsored annually by the Graduate School of Medicine of the University of Florida, was held this year at the MacFadden-Deauville Hotel in Miami Beach. The lectures on Ophthalmology were presented on January 16, 17 and 18, and those on Otolaryngology on January 19, 20 and 21.

The attendance was excellent, with 25 states, the District of Columbia and 2 foreign countries represented. The official attendance, including registrants, the committee in charge and the faculty, was 157; a number of guests were also present. Registration by states was: Florida, 30; Pennsylvania, 22; Ohio, 18; New York and Illinois, 8 each; Virginia, 7; West Virginia, Massachusetts, Wisconsin, Missouri, Michigan and Indiana, 4 each; Iowa, North Carolina and Kansas, 3 each; the District of Columbia, Georgia, New Jersey, South Carolina and North Dakota, 2 each; and Nebraska, Connecticut, Oklahoma, Mississippi, Minnesota and South Dakota, 1 each. There were 4 from Canada, 3 from Ontario and 1 from Quebec; and there was 1 from Cuba.

The distinguished faculty, composed of 10 members, presented a variety of subjects of timely interest, and the lectures were enthusiastically received. The ophthalmologists who lectured were: Dr. Arthur J. Bedell of Albany, N. Y.; Dr. Paul A. Chandler of Boston; Dr. Everett L.

Goar of Houston, Texas; Dr. Richard G. Scobee of St. Louis; and Dr. Frank B. Walsh of Baltimore. The lectures on otolaryngology were presented by Dr. Norton Canfield of New Haven, Conn.; Dr. French K. Hansel of St. Louis; Dr. Julius Lempert of New York City; Dr. Francis L. Lederer of Chicago; and Dr. Francis E. LeJeune of New Orleans.

Midwinter Meeting of Florida Society of Ophthalmology and Otolaryngology

The third midwinter meeting of the Florida Society of Ophthalmology and Otolaryngology took place at the MacFadden-Deauville Hotel in Miami Beach on Wednesday night, Jan. 18, 1950. As in previous years, this convention was held in conjunction with the annual Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Graduate School of Medicine of the University of Florida, in session there during the week of January 16.

Upon convening the scientific session at 8 p. m., Dr. W. Jerome Knauer of Jacksonville, President, reminded the large audience of members and guests that the Society, now ten years old, has attained an active membership of more than 100 members. He then reviewed the highlights of its history since Dr. H. Marshall Taylor of Jacksonville brought it into being in 1939 at the meeting of the Florida Medical Association in Daytona Beach by calling together the ophthalmologists and otolaryngologists present for the purpose of organizing. When formal organization was effected in Tampa the following year, Dr. Taylor appropriately became the first president and was succeeded in this office by the following members, in the order named: Drs. S. B. Forbes, Tampa; Shaler Richardson, Jacksonville; Carl E. Dunaway, Miami; Walter T. Hotchkiss, Miami Beach; William Y. Sayad, West Palm Beach; and Bascom H. Palmer, Miami.

Dr. Knauer further recounted that 20 members had presented scientific papers at the annual meetings, that formal adoption of a constitution and by-laws took place in 1947, that midwinter meetings had been held since January 1948, and that the treasury had been replenished throughout the decade not only by dues but also by a yearly gift from Dr. Forbes, which now is to become the nucleus of a scholarship fund. He then mentioned the imposing list of guest speakers over the years, which includes such eminent specialists as Drs. Frank E. Burch, Phillip Thygeson, Dillon

Geiger, the late Walter I. Lillie, Arthur Proetz, Frank B. Walsh, Henry L. Williams, John H. Dunnington, Samuel Fomon, Alan C. Woods, Algernon B. Reese, Louis H. Clerf, Ida Mann, Kenneth M. Day and Albert C. Furstenberg.

At the conclusion of this historical sketch, Dr. Knauer presented Dr. Taylor with the first past president's key. Dr. Taylor, in turn, presented keys to the other past presidents.

Dr. Julius Lempert, famous aural surgeon of New York City and the first of two distinguished guest speakers, then presented his motion picture entitled "The Fenestration Operation." The second speaker was Dr. Frank B. Walsh, Associate Professor of Ophthalmology, The Johns Hopkins University School of Medicine, Baltimore. His subject was "Some Ocular Signs of Malignant Tumors in the Nasal Pharynx."

Approximately 50 members of the Society attended this enthusiastic meeting. The presence of a large number of guests from all over the nation who were attending the Seminar increased the attendance to well over 200, and these visitors were warmly welcomed by the President before the meeting adjourned.

Earlier in the evening, the Society was host at a cocktail party honoring the physicians and their wives from out of the state.

On Monday night preceding the meeting, Dr. and Mrs. Knauer entertained at dinner at the Indian Creek Country Club in Miami Beach. The guests included the guest speakers, the past presidents and the officers of the Society and their wives.

Intern Association Linked to Reds

The Association of Interns and Medical Students, commonly referred to as AIMS, at its recent annual meeting at the University of Chicago voted to "disaffiliate" from the Communist-dominated International Union of Students. Nevertheless, according to the Chicago Tribune, this organization, which claims 2,000 members among medical students, hospital interns and resident physicians, voted "to cooperate with the International Union of Students (IUS) in arranging exchange of students, and to ask IUS to issue identity cards to American students."

Of the IUS, the Tribune story continued, report 271 of the House committee on un-American activities stated: "The World Federation of Democratic Youth brought into being the International Union of Students, which held a meeting

in Prague, August 17 to 31, 1946. The administration and direction of this project was entrusted to a 17-man executive committee, of whom 12 were known communists."

The Tribune account noted that Halsted Holman of Yale, 1948 president of AIMS, is a vice president of the IUS, and that Louis P. Rowland of New Haven Hospital, retiring AIMS president, was one of the sponsors last July in New York of the Bill of Rights conference of the Civil Rights Congress, labeled "subversive and communist" by Attorney General Clark.

Seminar on Tuberculosis Orlando, May 24-26

The Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association, the Florida State Board of Health and the Florida Tuberculosis and Health Association will present a Seminar on Tuberculosis at the State Tuberculosis Sanatorium in Orlando, May 24, 25 and 26, 1950. The first day will be devoted to case findings, the second to treatment and handling of the active tuberculous patient, and the third to follow-up care after the disease is arrested.

Revised Duval Monthly Bulletin

Each month there comes to the editor's desk a copy of the Monthly Bulletin of the Duval County Medical Society. It has come to be an old and trusted friend. With the March issue there came a pleasurable surprise. The Duval County Bulletin has obtained a New Look.

The attractiveness of a two-color cover invited closer inspection with the discovery of an entirely new format throughout. The Bulletin is bigger, better and more informative than ever.

The policy of the Bulletin perhaps is best exemplified by the lead editorial entitled, "We Grow." In this the editor reminds the members that although the society is growing rapidly, growth does not necessarily result in strength, nor is bigness of itself an indication of extensive service to mankind and the profession. There is a plea for greater active participation by the members in order that the Bulletin, the society and the medical profession may continue to grow and, not only be bigger, but better than ever.

The Journal congratulates the Duval Monthly Bulletin for its evidence of progress and is gratified for the reminder that no scientific periodical, and no professional organization can remain static; there can only be improvement or deterioration.

Pinellas Mail Bag

To the headquarters office recently has come a noteworthy example of the progressiveness of county medical societies. In order to provide a means of disseminating information to its members, and as a medium through which members may express themselves, the Pinellas County Medical Society has devised the *Picomeso Mail Bag*.

A perusal of the introductory Mail Bag indicates that it will be characterized by a variety of sections. In the sample copy submitted to this office there were scientific articles, a message from the president, a commentary by a Pinellas County dentist on a subject of mutual interest to both professions, news items, announcements and pertinent notices.

Significant among the news brought by the Mail Bag are two items which give evidence that these doctors are providing answers to the critics of voluntary methods of medical care. The members of the Pinellas Society have voted to assess themselves \$10.00 each in order to carry on a local Public Education Program. In addition, a "Volunteers for Emergencies" project is being started. Society members will take turns in standing by in order that doctors will be available at all times when needed.

The officers and members of the Pinellas County Medical Society are to be commended for initiating the Picomeso Mail Bag, and to be congratulated for their acceptance of the public challenge to medical men to prove that government controlled medical care is neither necessary nor desirable.

Information Medical Reserve Officers

Arrangements have been made through the cooperation of the Commanding Officer, Florida Military District, whereby Medical Reserve Officers are authorized to perform physical examinations for Florida National Guard units and receive the following retirement credits:

- a. For each physical examination conducted —1 credit hour
- b. For three credit hours—1 retirement point.

Unit commanders who utilize the services of Medical Reserve Officers will accomplish the certificates required for the obtaining of credit hours by the Medical Officers. The Military Sub-District Commanders or ORC Unit Instructors will advise the Medical Reserve Officers of the required documents to accrue credit hours.

Medical Reserve Officers who are interested should contact the Adjutant General, State of Florida; Commanding Officer, Florida Military District; or the Commander of the local Florida National Guard Unit.

Corren P. Youmans, /s/
Colonel, MC., FNG.

Medical Licenses Granted

Dr. Frank D. Gray, Secretary of the State Board of Medical Examiners, has reported that of the 136 applicants who took the examination of the Board, held November 28 and 29, 1949 in Jacksonville, 123 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 123 successful applicants follow:

- Abrams, Hyman Seelig, Tallahassee (Washington 1930)
Addams, Horace Whitley, Miami (Louisville 1949)
Alterman, Seymour Lewis, Coral Gables (George Washington 1947)
Artola, Robert Valdes, Chattahoochee (Havana 1940)
Auerbach, Seymour Pearson, Louisville, Ky. (Louisville 1949)
Axelrod, Arnold Raymond, Miami (Wayne 1944)
Bailey, Charles Denny, Orlando (Georgia 1949)
Baker, Thomas Justin, Miami (Indiana 1949)
Barry, Andrew Jackson, New Orleans, La. (Tulane 1949)
Baum, George Leonard, Coral Gables (New York U. 1940)
Bielek, Miles James, Chicago, Ill. (Illinois 1942)
Blais, Michael Roland, Daytona Beach (Tulane 1949)
Blakey, Hubert Hieronymus, Nashville, Tenn. (Vanderbilt 1949)
Bolton, Alexander Anderson, Jr., Coral Gables (Hahne-mann 1941)
Boyle, John Patrick, Hilliards, Ohio (Georgetown 1944)
Breakstone, Judd R., Miami Beach (Switzerland & Chicago 1939)
Broome, Robert Alexander, Jr., Durham, N. C. (Duke 1944)
Brown, Delmer Jencks, Orlando (Coll. Med. Evangelists 1940)
Brown, Marion Sanderson, Orlando (Coll. Med. Evangelists 1942)
Burris, Malcolm Bates, New Orleans, La. (Tulane 1943)
Butter, John Robinson, Minneapolis, Minn. (Minnesota 1941)
Byrne, Edward George, Daytona Beach (Louisville 1947)
Capmany, Fernando, Miami (Havana 1941)
Caukin, Howard Sprague, St. Petersburg (Northwestern 1948)
Cava, Edmund, Miami (Louisville 1949)
Chapman, Carrie Ethelyn, Rochester, Minn. (Tufts 1934)
Chase, Walter Everett, Martin, Mich. (Rush 1939)
Childers, Stanley Gray, Robertsedale, Ala. (Oklahoma 1945)
Christian, Eugene Elmore, (Col.), Belle Glade (Coll. Phys. & Surg. 1947)
Cloud, Ishmail Graydon, Tampa (Tennessee 1949)
Cohn, Bertram Douglas, Sanford (New York U. 1948)
Cross, John Duling, DeLand (Temple 1945)
Cunningham, David Harvey, Hartford, Conn. (New York Med. 1944)
Debo, Raymond Anthony, Dayton, Ohio (Cincinnati 1948)
Diecidue, Alfonso Anthony, Tampa (Loyola 1947)
Edgerton, Milton Thomas, Jr., Atlanta, Ga. (Johns Hopkins 1944)
Ehrenreich, Jacob, Miami (Buffalo 1949)
Eskridge, Jack, Galveston, Texas (S. E. Med. Coll. 1946)
Evans, Meredith James, Miami (Louisville 1949)
Faircloth, Robert Sears, Norfolk, Va. (Med. Coll. Va. 1941)
Ferris, James W., Sarasota Beach (Marquette 1937)
Flautt, James Robert, Jr., Rochester, Minn. (Tennessee 1944)
Freed, Leonard, New York, N. Y. (Middlesex 1943)
Gallo, John Pasquale, Miami Beach (Kansas City U. 1944)
Gay, Francis Marion, Moultrie, Ga. (Emory 1940)
Goodman, James Jacob, Ft. Steilacoom, Wash. (Middlesex 1945)
Greenburgh, Harrien William, Memphis, Tenn. (Tennessee 1931)
Griffith, Daniel Plunkett, Orlando (Georgia 1949)
Griffitts, James John, Miami (Virginia 1937)
Grochowski, Ernest Michael, Chicago, Ill. (Loyola 1943)
Hadley, William Pullen, Gainesville (Duke 1948)
Hall, Wilbur Dallas, Calhoun, Ga. (Emory 1934)
Hamburger, Stuart Wallace, Miami (Jefferson 1949)
Hamilton, Walton Winslow, Jacksonville (Arkansas 1948)
Hege, John Roy, Jr., Birmingham, Ala. (Duke 1942)
Hogg, Bruce MacLean, New Rochelle, N. Y. (Coll. Phys. & Surg. N. Y. 1933)
Hyde, Albert Marshall, Jacksonville (Oregon 1948)
Jacobs, Frederick Matthews, Memphis, Tenn. (Virginia 1933)
Jahn, Paul Herbert, Winter Haven (Harvard 1947)
Jarrett, Paul Stuart, Rochester, Minn. (Indiana 1945)
Jensen, Louis Christian, Jr., Miami (Minnesota 1946)
Johnson, David Eugene, Orlando (Georgia 1949)
Joy, Ernest H., Key West (Tufts 1932)
Karelas, George William, Flowery Branch, Ga. (Kansas City U. 1943)
Kaufman, Paul, Washington, D. C. (George Washington 1947)
Kaye, Harry Donglai, New Orleans, La. (Harvard 1943)
Klenk, Leo Francis, Pensacola (Georgetown 1938)
Knight, Frederick Coyne, Tampa (Coll. Med. Evangelists 1944)
Koontz, Emory Ransom, St. Petersburg (Michigan 1932)
Krausz, Marguerite, Coral Gables (Tufts 1930)
Lamb, Ernest Emerson (Col.), Ocala (Meharry 1949)
Langer, Edward Maurice, West Springfield, Mass. (Scotland 1937)
Lauer, John Albert, Jr., Jacksonville (Coll. Med. Evangelists 1949)
Longino, Grady Estes, Chamblee, Ga. (Emory 1947)
Lukens, Morris Harold Richard, Orlando (Coll. Med. Evangelists 1941)
Lundquist, John Richard, Pensacola (Buffalo 1946)
McCook, Walter Ramon, Miami (Virginia 1949)
McCorkle, James Kenneth, Rochester, Minn. (McGill 1940)
McKell, Thomas E., New Orleans, La. (Tennessee 1939)
Malitz, Sidney, Miami (Chicago 1947)
Messiter, Norman Uriah, Miami (Northwestern 1948)
Miller, John, Greenwich, Conn. (Cornell 1915)
Millman, Bernard Meyer, Ft. Lauderdale (Kansas City U. 1939)
Montgomery, Robert Henry, Mt. Dora (George Washington 1946)
Mueller, Marie Luise Allespach, Miami (Boston Coll. Phys. & Surg. 1947)
Myerson, Samuel, St. Petersburg (Cornell 1928)
Nayfield, Chester Leonard, Jacksonville Beach (Middlesex 1940)
Neber, Jacob, Miami Beach (Tufts 1938)
Nickel, Frank William, Winter Park (Illinois 1910)
Norville, Wilbert Otto (Col.), Belle Glade (Coll. Phys. & Surg. 1948)
Osman, Daniel Allan, Miami (Chicago 1949)
Patterson, Joseph Flanner, Jr., Philadelphia, Pa. (Harvard 1942)
Peoples, William Jackson, Key West (Georgia 1943)
Quigley, Joseph Bernard, Indianapolis, Ind. (Indiana 1938)
Ramey, John Robert, Miami (Cincinnati 1945)
Ritch, Thomas Griffin, Jacksonville (Emory 1946)
Rodman, Clark, Coral Gables (Jefferson 1943)
Rose, Isadore, Philadelphia, Pa. (Jefferson 1946)
Rowan, Paul Joseph, St. Petersburg (Pennsylvania 1945)

Rumball, John Marcas, Coral Gables (Minnesota 1935)
 Ryan, Albert Olen, Jr., Lakeland (Cincinnati 1947)
 Ryan, Maxwell Donnell, New York, N. Y. (McGill 1927)
 Salon, Joel Warren, Miami (Michigan 1946)
 Sandberg, Theodore Ernest, Pittsburgh, Pa. (South Carolina 1948)
 Schoetker, George Henry, Clearwater (St. Louis 1930)
 Serlin, Oscar, Coral Gables (Dalhousie 1941)
 Shain, Joseph Herman, South Norwalk, Conn. (Tufts 1928)
 Shashy, Robert Abraham, Miami (South Carolina 1949)
 Sherman, Henry Thomas, Valdosta, Ga. (Cornell 1934)
 Smartt, Walter Haines, Miami (Virginia 1948)
 Smith, Amaziah Parker, Lake City (Johns Hopkins 1945)
 Spray, Paul Ellsworth, Rochester, Minn. (George Washington 1944)
 Streets, Benjamin Franklin, McKeesport, Pa. (Hahnemann 1940)
 Studybaker, Samuel Philip, Miamisburg, Ohio (Hahnemann 1947)
 Sweet, Arthur, St. Petersburg (Illinois 1944)
 Swords, Collins Ward, Jr., Miami (Michigan 1948)
 Trygstad, Ethel Hirsch, Clearwater (Columbia 1927)
 Varley, Irving Weeks, Tampa (Arkansas 1948)
 Whitehead, Thomas, Miami (Wayne 1949)
 Wilcox, Abbott Yates, Jr., Bay Pines (Pennsylvania 1930)
 Wing, Breckinridge Wilmer, Winter Park (Pennsylvania 1943)
 Wolfe, Charles Julian, Augusta, Ga. (Buffalo 1949)
 Young, Thomas Roger, Jr., Chicago, Ill. (Illinois 1942)

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bevis, William M., Lakeland
 Chandler, James R., Jr., Daytona Beach
 Collins, Harry L., Jr., Umatilla
 Cooke, Francis N., Washington, D. C.
 Covington, Aubrey Y., Starke
 Cross, John D., DeLand
 Eisenman, Leon S., Okeechobee
 Grau, Sidney, St. Petersburg
 Graves, Leander J., Tallahassee
 Johnson, William S., Lakeland
 Kantor, Samuel, Miami Beach
 King, Herbert A., Daytona Beach
 Lawrence, Howard F., St. Petersburg
 Lores, Manuel C., Miami
 McCall, Joel V., Jr., Daytona Beach
 Margoshes, Stanley, Miami
 Massey, George H., Quincy
 Mendel, James H., Jr., Miami
 Morey, Horace F., Miami
 Perry, Joseph Q., Pensacola
 Rand, George L., Miami Beach
 Ray, John A., Mulberry
 Ring, Harold H., Naples
 Robertson, George W., III, Miami
 Rogers, Ruth T., Daytona Beach
 Roush, Dwight I., Pinellas Park

Speers, Dorothy J., Titusville
 Speers, James F., Titusville
 Summerlin, Glenn O., Gainesville
 Thomas, William C., Jr., Gainesville
 Watson, John L., Miami

YOUR BLUE SHIELD

Thank You, Doctor

All-out efforts are still being made by Blue Shield and Blue Cross representatives to convert all present subscribers to the new Series "7" contract at the earliest possible moment for each group. The reception given the new contract by many groups is very encouraging and the Blue Shield Plan wishes to extend its appreciation to all doctors who have cooperated in changing their own particular group to this new contract, and whose secretaries have adapted themselves to the new benefits under this contract in the use of the new Doctor's Service Reports. It is hoped that by June 1, the majority of subscribers will be on the new Series "7" contract.

For Your Convenience

During recent months the Florida Blue Shield and Blue Cross Plans have inaugurated a Professional Relations Program for the benefit of doctors and hospitals participating in these two plans. Professional Relations Representatives are now stationed in four areas throughout the State and are available at any time to assist you in any way possible. You may possibly wish a representative to call on your secretary and explain the new contract to her, particularly if she has not been in your employ very long. In addition to an explanation of the benefits provided under the new contract and the necessary forms to be completed for Blue Shield cases, the representative will give your secretary a brief history of the Blue Shield and Blue Cross movements and their importance in the American way of life. The following is a list of the Blue Shield-Blue Cross Professional Relations Representatives who are always available to be of service to you. John C. Lee, 411 Chamber of Commerce Building, Miami; Frank T. Stallworth, Tallahassee Memorial Hospital, Tallahassee; Leonard Brown, Room 21, Western Union Building, Tampa and James Hughes, P. O. Box 1798, Jacksonville. Contact them directly or through the Jacksonville office of the Plan, P. O. Box 1798.

Blue Shield Annual Meeting

Plan to attend the annual meeting of the Florida Medical Service Corporation which will be held on Sunday, April 23, 1950, at 4:00 p.m. in the Hollywood Beach Hotel, Hollywood, Florida, the day prior to the opening of the Annual Meeting of the Florida Medical Association. Take part in the election of Board members and have a voice in the affairs of the corporation.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Jackson L. Allgood, Jr., of Jacksonville announce the birth of a son on Nov. 22, 1949.

Dr. and Mrs. Matthew E. Morrow of Jacksonville announce the birth of a daughter, Elizabeth Chase, on Feb. 6, 1950.

Dr. and Mrs. J. Ellis Lanier of Jacksonville announce the birth of a son on Feb. 6, 1950.

Dr. and Mrs. Walker Stamps of Jacksonville announce the birth of a daughter on Feb. 14, 1950.

Dr. and Mrs. C. Burling Roesch of Jacksonville announce the birth of a daughter on Feb. 9, 1950.

Dr. and Mrs. William A. Van Nortwick of Jacksonville announce the birth of a son on Jan. 12, 1950.

Deaths — Members

Silverio, Juan, Miami 1949

Deaths — Other Doctors

Ellis, Samuel B., Pitts, Ga. 1950

WANTED: Association with busy practitioner, purchase practice or place to locate, preferably Tampa. Age middle 40's; experienced; Florida license; references furnished. Write 69-32, P. O. Box 1018, Jacksonville, Florida.

RADIOLOGIST SEEKS ASSOCIATION: With Hospital, Group, or other Radiologist. Board Diplomate, Diagnosis and Therapy. Age 35. American, Cornell Graduate, healthy, hard worker. Florida license. Write 69-33, P. O. Box 1018, Jacksonville, Fla.

Important Notice: All Florida diplomates of the National Board of Medical Examiners are urged to send their names and addresses to Dr. Kenneth Phillips, 1150 S. W. 22nd St., Miami 36, Florida prior to the annual convention of the Association in Hollywood.

STATE NEWS ITEMS

Consult your March Journal for information regarding the Annual Meeting in Hollywood, April 23-26. This issue carries the complete program of the Convention.

Dr. Sullivan G. Bedell of Jacksonville spoke before the Junior Woman's Club at a January meeting on "The Problem of Security."

Dr. Ashbel C. Williams of Jacksonville was the guest speaker at a supper meeting of the Junior Woman's Club in February. Dr. Williams discussed problems arising from cancer.

Dr. Walter C. Payne, president, spent February 21 and 22 in Jacksonville at the headquarters office on matters of Association business.

Dr. Herbert W. Virgin, Jr., announces the removal of his offices to 525 Northeast 15th Street, Miami. Dr. Virgin will limit his practice to orthopedic surgery.

Dr. Wilbur C. Sumner of Jacksonville chose the subject of cancer in a talk before the Ware County Medical Society in Waycross, Georgia.

Dr. Bernard J. McCloskey of Jacksonville discussed cancer at a meeting of the Alpha Phi Omega Sorority.

Dr. Norman F. Coulter of Orlando recently spoke before the Zonta Club of Orlando-Winter Park. Dr. Coulter discussed the need for early diagnosis of cancer and explained that a high percentage of cures are obtained in the cases of early diagnosis as compared with those in which there has been considerable delay.

Dr. J. K. David, Jr., of Jacksonville addressed the Junior Woman's Club of South Jacksonville in November on "Infant Development."

Dr. Herbert L. Bryans of Pensacola recently was re-elected president of the Florida State Board of Health for his ninth consecutive year.

Dr. Luther W. Holloway of Jacksonville has returned to his practice following his attendance at a board meeting of the Southern Pediatric Seminar at Spartanburg, South Carolina.

Dr. E. Frank McCall of Jacksonville was on the program of the scientific session of the South Atlantic Association of Obstetricians and Gynecologists at a recent meeting in Roanoke. Dr. McCall's subject was "Diabetes Complicated by Pregnancy."

Dr. John A. Coleman of Plant City has been elected chairman of the County School Trustees for 1950.

Dr. Joseph S. Stewart of Miami, chairman of the Committee on Public Relations and chairman of the State Education Campaign Committee, Dr. Walter C. Payne, president, Dr. Robert B. McIver, secretary-treasurer and Mr. William Harold Parham, supervisor of the Bureau of Public Relations, represented the Florida Medical Association at the Second Conference of the National Education Campaign held in Chicago on February 12.

Dr. Donald W. Hedrick of Tampa addressed the Tampa District Society of X-Ray Technicians. Dr. Hedrick presented several interesting orthopedic cases.

Dr. Bernard Goodman of Miami Beach recently spoke on mental hygiene at the monthly meeting of the Dade County Deans' and Counsellors' Association.

Dr. Erna K. Klass of Miami recently spoke to the Young Matrons Club of the Y. W. C. A. on the subject of "Discipline."

The Southeastern Section of the American Urological Association will hold a five-day Postgraduate Seminar at the Brown Hotel, Louisville, Kentucky, October 9-13, 1950. The Seminar will be under the sponsorship of the University of Louisville School of Medicine and doctors interested in attending the Seminar should contact the chairman, Dr. Robert Lich, Jr., Louisville.

Dr. Joseph S. Stewart of Miami was named president-elect of the Southeastern Surgical Congress at its meeting in Washington, D. C., March

6-9. Dr. Stewart will take office at the meeting of the Congress in Hollywood, April 11-14, 1951.

Dr. Robert B. McIver, Stewart Thompson and Ernest Gibson spent the entire day at the Hollywood Beach Hotel, Sunday, March 12, conferring with hotel officials and working on details of the plans for the annual convention, April 23-26. By referring to the program in your March Journal, you will observe how complicated and multitudinous are the details which these plans require. Numerous visit have been made to the headquarters hotel beginning in 1949.

Fifteen of the Broward County Medical Society doctors under the leadership of Dr. Lloyd U. Lumpkin, general chairman, met for a conference and lunch at noon with the Florida Medical Association representatives. Several hours were spent in an informative discussion regarding plans for the various entertainment activities.

In addition to Dr. Lumpkin, the following local doctors were present: Edward A. Abbey, Norris M. Beasley, Curtis D. Benton, Jr., Herman L. Boese, Julius F. Boettner, Milton N. Camp, Russell B. Carson, Alfred E. Cronkite, Robert R. Harriss, Royle B. Klinkenberg, Richard A. Mills, Raymond M. Price, Randall W. Snow and William D. Wells.

COMPONENT SOCIETY NOTES

Alachua

As a special health service to the people of the community, members of the Alachua County Medical Society are presenting a series of articles on the seven danger signals of cancer. Each article will be written by a member of the society and presented to the public through the columns of the local newspaper.

Brevard

The Brevard County Medical Society, at its February meeting, was honored with three out-of-state speakers: Dr. Robert Ivey of the University of Pennsylvania School of Medicine, who discussed "Cleft Palate," Dr. Fred Hauser of the University of Pennsylvania School of Medicine, who discussed "The Allergic Nose," and Dr. Jacob Vastine of Woman's Medical College of Pennsylvania, whose subject was "Bone Growth."

Eighty persons attended the meeting. In addition to the members of the Brevard Society, the following guests were present: General Norman T. Kirk and Dr. J. J. Clark, Atlanta; Dr. Ralph E.

Balch of Kalamazoo, Michigan; Dr. John Brooke of Philadelphia, Pa.; Dr. C. Budd Corbus of Chicago; Dr. Goldberg of New Haven, Connecticut; Dr. Gibley of Wilkes Barre, Pa.; Major Edward Miller and Dr. Roper of Joint Long Range Proving Grounds; and Drs. Fred H. Albee, Jr., Courtlandt D. Berry, Chas. J. Collins, Paul H. Ducharme, James G. Economon, Elwyn Evans, Eugene L. Jewett, Duncan T. McEwan, Fred Mathers, Don C. Robertson, A. Fred Turner, Jr., and Richard H. Walker, Orlando. A number of members of the dental profession also were guests.

Dade

The Dade County Medical Association, at a February meeting, had as its guest speaker, Dr. Richard L. Meiling, director of the medical services office of the department of defense. Dr. Meiling described war and peacetime services of his department.

Duval

Dr. Robert S. Hotchkiss, professor of urology and chairman of the department of urology at the New York University Medical Center, was the guest speaker at the February meeting of the Duval County Medical Society. He spoke on the topic, "Fertility in the Male."

Escambia

Members of the Escambia County Medical Society entertained the doctors of the Naval Air Station recently at the Pensacola Country Club.

Marion

At the February meeting of the Marion County Medical Society, thirty-two members and guests were present. Dr. John J. Chiliden, former professor of proctology at the Jefferson Medical College of Philadelphia, presented a talk on problems in proctology of the general practitioner. The following members were present: Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, Carl S. Lytle, Eaton G. Lindner, John D. Lindner, William J. McGovern, Robbins Nettles, Eugene G. Peek, Jr., Ralph E. Russell and Thos. H. Wallis, Ocala, and Clifford E. Vinson, Williston.

Monroe

The Monroe County Medical Society met jointly with the medical staff of the U. S. Naval Hospital at Key West to hear an address on cancer by Dr. Fred W. Rankin. Dr. Rankin's sub-

ject was "Surgery of the Lower Gastrointestinal Tract" with special emphasis on "Cancer of the Colon."

Nassau

All members of the Nassau County Medical Society have paid 1950 state dues.

Polk

Dr. McGehee Harvey, professor of clinical medicine at Johns Hopkins University School of Medicine, was the guest speaker at the Polk County Medical Society's regular meeting on February 8, in Lake Wales. Dr. Harvey's subject was "Rheumatoid Arthritis and the Newer Treatments."

Seminole

State dues for 1950 have been paid by all members of the Seminole County Medical Society.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those who have come to the attention of The Journal.

Dr. Edward Canipelli, Jacksonville, Ponce de Leon General Assembly Fourth Degree, Knights of Columbus
Dr. William M. Rowlett, Tampa, weekly AI & E lecture, MacDill Field.
Dr. Edward W. Cullipher, Miami Woman's Club
Dr. William M. Rowlett, Tampa, Hillsborough Federation of Women's Club
Dr. Gordon H. Ira, Jacksonville, Council of Jewish Women
Geoffrey H. Binneveld of Leesburg, local Business and Professional Woman's Club
Robert J. Needles of St. Petersburg, local Woman's Democratic Club
Edward R. Annis of Miami, Northside Kiwanis Club
Joseph S. Stewart of Miami, local Republican Headquarters Club
Frank G. Slaughter of Jacksonville, Jacksonville Exchange Club
Irving J. Strumpf of Jacksonville, Hendricks Ave. School Dad's Club and P. T. A.
Joseph S. Stewart of Miami, local Republican Headquarters Club
Walter H. Winchester of Dunedin, local Rotary Club
Charles K. Donegan of St. Petersburg, local insurance women
Donald W. Smith of Miami, Southeastern Pharmaceutical Association meeting in Miami
Gordon H. Ira of Jacksonville, Murray Hill Citizens Club
Gordon H. Ira of Jacksonville, local Altrusa Club
Frank G. Slaughter of Jacksonville, local Exchange Club

OBITUARIES**Harry Hausman**

Dr. Harry Hausman of Daytona Beach died at Halifax District Hospital in that city on Jan. 8, 1950. A victim of heart disease, he was 64 years of age. Interment took place in New York City.

A native of Hungary, Dr. Hausman came to this country when he was a child. He was graduated from the New York University College of Medicine in 1908 and received further training at St. Mark's, Lexington, Harlem, St. Luke's and Bellevue hospitals in New York City. He was licensed to practice medicine in New York in 1908, New Jersey in 1909 and Florida in 1939.

Dr. Hausman came to Daytona Beach from New York and had practiced there since 1941. He was senior urologist and proctologist at Halifax District Hospital. He was a member of B'nai Brith, Temple Israel and Daytona Beach Masonic Lodge 270.

A member of the Volusia County Medical Society, the Florida Medical Association and the American Medical Association, Dr. Hausman also held membership in the American Urological Association and the New York County Medical Society.

Survivors include his widow, Mrs. Beatrice Hausman; one son, Benjamin, a student at Emory University School of Medicine; one brother, Sam; and three sisters, Miss Mary Hausman, Mrs. Lina Kest and Mrs. Ella Karovin, all of New York City.

Robert Henry McGinnis

Dr. Robert Henry McGinnis of Jacksonville died at Riverside Hospital in that city on Dec. 27, 1949. He was 80 years of age. Interment took place in Charlotte, N. C.

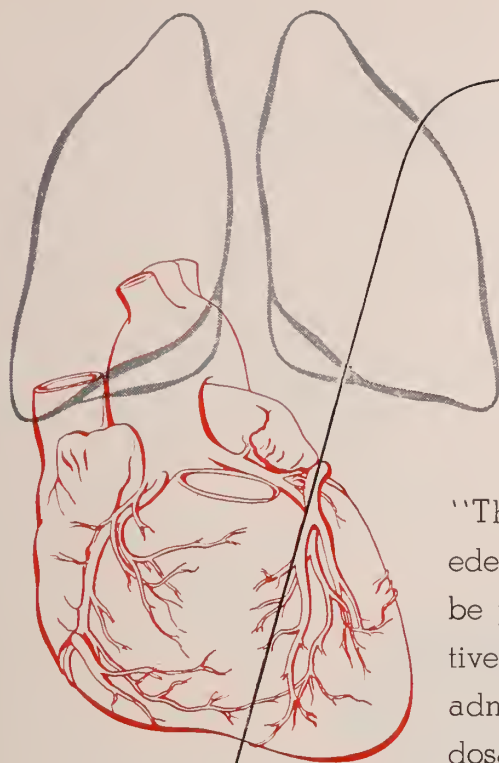
One of Florida's oldest and most distinguished physicians, Dr. McGinnis was born in North Carolina on Nov. 15, 1869. He was graduated from the University of Maryland Medical School in 1897. After serving an internship at the Uni-

versity of Maryland Hospital in Baltimore, he located in Jacksonville in 1898 and became associated in the practice of medicine with the late Dr. James D. Love, a classmate at medical school. He remained in active practice there as a specialist in internal medicine until his retirement in 1936.

For many years Dr. McGinnis served as chief of the department of medicine of the Duval County Hospital and was revered as one of its guiding spirits. He gave generously of his time and talents to the indigent for thirty-five years, as attested by a plaque honoring him for his continuous and gratuitous service, which now hangs in the Duval Medical Center. The establishment of the hospital's tuberculosis clinic was due in large measure to him. He was also a member of the staff of St. Luke's Hospital, an institution in which he had a particular interest. Last October he left a sick bed to attend a celebration in his honor on the occasion of the opening of the Sellers Auditorium, the new permanent home of the Duval County Medical Society.

At the time of his death, Dr. McGinnis was the oldest living past president of both the Florida Medical Association, of which he was a life member, and the Duval County Medical Society. In 1915 he served the Association in its highest office and in later years was active on the publications, necrology and president's advisory committees. Previously, from 1904 through 1907, he was president of the Duval County Medical Society. In addition, he held membership in the American Medical Association and the Southern Medical Association. When he joined the American College of Physicians in 1921, he became one of the earliest members in this state. He was also a member of the Florida governing committee of the Gorgas Memorial Institute of Tropical and Preventive Medicine.

The only relative, a brother, Eugene C. McGinnis of Raleigh, N. C., survived him but a few weeks.



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1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

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Leon Hardie O'Quinn

Dr. Leon Hardie O'Quinn died at his home in Hialeah on Dec. 13, 1949. He was 51 years of age.

The youngest of 10 children, Dr. O'Quinn was born on Christmas morning in 1897 at Odum, Ga. He received his academic training at Mercer University, Macon, Ga., and Emory University, Oxford, Ga., and completed his medical education at Emory University School of Medicine, Atlanta, Ga., where he was graduated in 1923. He interned at Maryland General Hospital, Baltimore. His schooling was interrupted during World War I when he joined the ranks of the Emory Unit, Base Hospital No. 43, and served at Blois, France for a year. During World War II he acted as examining physician in cooperation with the draft board.

After practicing for a short time in Brunswick, Ga., Dr. O'Quinn came to Florida in 1924 and for a quarter of a century ministered to the medical needs of the Hialeah-Miami Springs area. He enjoyed a wide reputation for humanitarian service, won in particular by his heroic work for storm sufferers in the hurricanes of 1926 and 1935 and the flood of 1947. A former mayor of Hialeah, he was active in civic affairs and served as city physician through several administrations. He was a past commander of the Sullivan-Babcock Post, American Legion, Hialeah, and a member of the Hialeah-Miami Springs Elks Lodge and Kiwanis Club, the 40 & 8 Society of the American Legion, and the Hialeah Baptist Church.

Dr. O'Quinn was a member of the Dade County Medical Association, the Florida Medical Association, the American Medical Association and the Southern Medical Association.

In addition to his widow, Mrs. Pauline O'Quinn, he is survived by two brothers, L. F. and L. E., of Miami; and four sisters, Mrs. Lizzie Tyson, Jessup, Ga., Mrs. Lona Odum, Odum, Ga., Mrs. Lois Spence, Lakeland, Ga., and Mrs. Leottie Odum, Miami.

Thomas Riffel Purcell

Dr. Thomas R. Purcell of Clearwater crashed to his death in his private plane at Pahokee on Jan. 14, 1950. He was 47 years of age.

Dr. Purcell was born at Panasoffkee on March 6, 1903. He attended Fordham High School and Columbia University in New York City and continued his medical studies at the University of

(Continued on Page 654)

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From where I sit, if a man wants to use his left hand—that's *his* business. It's not a good idea to make anyone do things our way, because *we* think it's right. Personally, I think a mellow glass of beer is the finest beverage on earth. If you happen to prefer a Coke—why, go to it! Only leave me the same freedom of choice, won't you?

Joe Marsh

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problem

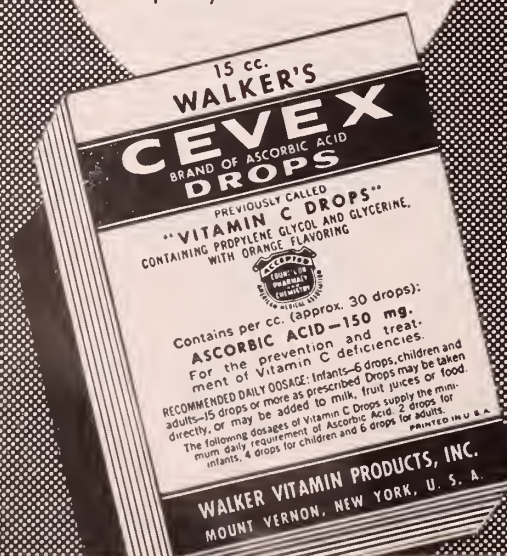
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Minnesota and the University of Arkansas, graduating from the School of Medicine of the latter institution in 1938. He then interned at the Jersey City Medical Center, Jersey City, N. J., and served a residency at Fitman Memorial Park Hospital, Asbury Park, N. J.

In 1939 Dr. Purcell came to Tarpon Springs and practiced there until he entered the Army in 1941 as a captain in the medical corps. He served overseas in England, then as a division surgeon participated in the Normandy and Northern France campaigns, returned to England wounded and upon recovery saw further duty there before returning to the United States. He was released to inactive duty in December 1945 with the rank of major.

Dr. Purcell then located in Clearwater, where he engaged in general practice, majoring in surgery. He was a member of St. Cecelia's Catholic Church, the American Legion, the Veterans of Foreign Wars and the Clearwater Yacht Club.

A member of the Pinellas County Medical Society, Dr. Purcell also held membership in the Florida Medical Association and the American Medical Association.

Surviving are his widow, Mrs. Florence M. Purcell; three sons, Thomas R., Jr., Raymond English and Edwin J.; his mother, Mrs. Julia Margaret English; one brother, Dr. Edwin J. Purcell of Tucson, Ariz.; and one sister, Mrs. George W. Connell of New York City.

Ernst P. E. Sengstak

Dr. Ernst P. E. Sengstak of Daytona Beach died there in Ridgewood Hospital of virus pneumonia on Dec. 5, 1949. He was 72 years of age.

Born at Loveland, Ohio, in 1877, Dr. Sengstak received his medical degree from Baylor University College of Medicine, Dallas, Texas, in 1905, took postgraduate work at Chicago Polyclinic Institute that same year and also attended the University of the South, Sewanee, Tenn.

From 1905 until 1927, when he retired and moved to Daytona Beach to manage his father's estate, Dr. Sengstak practiced medicine in Jacksonville. He retained membership in the Jacksonville Knights of Pythias Lodge.

Dr. Sengstak was a life member of the Duval County Medical Society and of the Florida Medical Association, holding membership for 42 years, and was also a member of the American Medical Association.

He is survived by his widow, Mrs. Ernestine M. Sengstak, and his mother, Mrs. Martha Amy Sengstak, both of Daytona Beach; two sisters, Mrs. Amy Baird, also of Daytona Beach, and Mrs. Gay Morgan, Darien, Conn.

John Augustus Toomey

Dr. John A. Toomey of Cleveland, Ohio, stricken on Dec. 17, 1949, died of recurring cerebral hemorrhage on Jan. 1, 1950, in Cleveland City Hospital. He was 60 years of age.

A native of Ohio, Dr. Toomey was born in Cleveland on May 25, 1889. He was educated in that city, receiving the Bachelor of Arts degree in 1910 and the Master of Arts degree two years later from the John Carroll University, which institution conferred upon him the honorary degree of Doctor of Laws in 1949. He was awarded the Bachelor of Laws degree from the Cleveland Law School in 1913 and in 1919 the degree of Doctor of Medicine from Western Reserve University School of Medicine.

Through academic ranks Dr. Toomey rose from demonstrator to professor in his alma mater, where he was Professor of Clinical Pediatrics and Contagious Diseases when death ended his twenty-nine years of service on the medical faculty. It also brought to a close thirty-seven fruitful years at City Hospital, where he had interned and served a residency, and where he had become head of the Contagious Diseases Division in 1922. At the time of his death he was Associate Director of Pediatrics and Contagious Diseases there.

A recognized authority on the treatment of poliomyelitis, this distinguished pediatrician pioneered in a method said to be one of the most effective aids in the recovery of patients with this disease. His contributions to medical literature, numbering over 350, attest his great interest in clinical investigation and laboratory research. He was co-editor of the Archives of Pediatrics.

In 1948 Dr. Toomey served as president of the American Academy of Pediatrics, of which he was also a fellow. He was a member of numerous medical organizations, both state and national, and was a fellow of the American College of Physicians, the American Medical Association, the Ohio Academy of Science, the American Public Health Association, the American Society of Immunologists and the American Association for the Advancement of Science. In April 1948 he joined

(Continued on Page 656)

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GYNECOLOGY—Intensive Course, Two Weeks, starting April 17, June 19. Vaginal Approach to Pelvic Surgery, One Week, starting May 15.

OBSTETRICS—Intensive Course, Two Weeks, starting April 3, June 5.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3. Personal Course in Cerebral Palsy, Two Weeks, starting July 31. Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.

MEDICINE—Intensive General Course, Two Weeks, starting April 24. Electrocardiography & Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastro-enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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the Dade County Medical Association and thus became a member of the Florida Medical Association.

Years ago, Dr. Toomey married Miss Mary L. Bagot, who died in 1947. Last October he married Miss Helen K. Toomey of Fort Lauderdale, formerly of Painesville, Ohio, who survives him. Also surviving are four children, Dr. Charles H., at Bellevue Hospital, New York City, John A., Jr., a law student, Frances, a medical student at Marquette University School of Medicine, and Mrs. Mary Louise Quinn, a law student, of Cleveland; and three brothers and three sisters.

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Convention Highlights

Hollywood, Convention City! Doesn't that sound exciting and glamorous to physically and mentally tired doctors' wives throughout Florida? It should be the mecca for one and all of us on April 23-26, not only for rejuvenation of tired bodies and minds, but for the exhilarating influence of the notable guests expected. The name Hollywood, itself, is suggestive of tropical splendor to captivate the imagination of all especially those of us who come from north and west Florida. We are anticipating with much pleasure the many affairs being planned for us by the Auxiliary members of Broward County, Mrs. S. Elliott Wilson, president. We hope that you will plan to arrive on Sunday so that we may have ample

opportunity for becoming better acquainted. You will find the complete program in the March Journal which is the convention issue.

On Monday morning at 9:30, the officers, chairmen of committees, county presidents and presidents-elect, will convene for the Pre-Con-vention Board Meeting. Bring any problem that you may have to this meeting for full discussion.

We will be honored by having our National President of the Woman's Auxiliary to the American Medical Association, Mrs. David B. Allman, speak to us at our luncheon meeting on Monday. It is very important that every doctor's wife hear the message she has for us. In addition to our National President, we are privileged to have Mrs. Robert C. Haynes, President of the Woman's Auxiliary to the Southern Medical Association, who will also bring to us a very timely message.

On Monday afternoon, the hostess Auxiliary will give a Tea honoring both Mrs. David B. Allman and Mrs. Robert C. Haynes. An invitation is extended to all of us to attend the Smoker with our husbands in the evening.

Since Monday could be aptly termed our day of inspiration, then Tuesday could be called the day of gratification, for on that day, each officer, chairman and county president will have the privilege of giving glowing reports of their many and varied activities for the past year. The luncheon on that day will be another memorable event. Guests of honor will be Dr. Walter C. Payne, President of the Florida Medical Association, Dr. Herbert E. White, President-elect of the Florida Medical Association together with all Past Presidents of the Woman's Auxiliary to the Florida Medical Association.

Guest speaker on this occasion will be scintillating and enthusiastic Miss Mary McGinn of National Education Campaign Headquarters, Chicago. She has a vital message for all doctors' wives. In the evening, we are again invited to attend the Annual Dinner with our husbands.

This meeting has every indication of being the most dynamic one ever held. It is of paramount importance that doctors' wives from every town and hamlet attend, so let me urge you not to miss any one part of this important Convention.

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Woman's Auxiliary to the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

The Woman's Auxiliary of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held its regular quarterly meeting January 19, 1950 in the Library of the Tallahassee Memorial Hospital, with the Tallahassee members as hostesses. The president, Mrs. Merritt R. Clements of Tallahassee, presided.

Mrs. Charles F. Henley of Jacksonville, president of the Woman's Auxiliary to the Florida Medical Association, was a special guest. She gave a message on the action Auxiliary members could and should take to help prevent socialized medicine.

Guest speaker for the afternoon was Samuel R. Neel, Ph.D., of the Florida State University. He gave a very interesting talk on "The Christian Way to Meet the Tension of Modern Affairs."

Another highlight of the afternoon was a tour of the new Tallahassee Memorial Hospital. The ladies then joined the doctors and their guests for dinner and dancing at the Country Club.

BOOKS RECEIVED

THE SALT-FREE DIET COOK BOOK. By Emil G. Conason, M.D., and Ella Metz. Price, \$3.00. Pp. 144. New York: Lear Publishers, Inc., 1949.

Dr. Conason discusses the development of the salt-free diet in modern medicine and then presents out of the experience of his practice a series of tested and proved menus. Care has been taken to work out a variety of meals designed to overcome the frequent resistance of dieters to the insipid fare generally imposed upon those requiring freedom from salt. These menus are supplemented by handy recipes and reliable salt-content tables making possible even greater variety through the substitution of other foods with low salt content. There are special sections of weight-reducing menus and low sodium diets for the diabetic.

PROGRESS IN NEUROLOGY AND PSYCHIATRY, AN ANNUAL REVIEW. Vol. IV. Edited by E. A. Spiegel, M.D. Price, \$10.00. Pp. 592. New York: Grune & Stratton, Inc., 1949.

This annual review of neurology and psychiatry sets forth as complete a picture of recent developments as possible within the limitations of space and at the same time offers a balanced picture in which each discipline is afforded a fair representation. The four basic subdivisions of basic sciences, neurology, neurosurgery and psychiatry have been retained. Obviously, practitioners will also find useful material in the theoretic chapters, and many problems pertaining to the sphere of interest of psychiatrists are discussed under such subjects as endocrinology, vegetative innervation, cerebrospinal fluid and psychosurgery.

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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1945.

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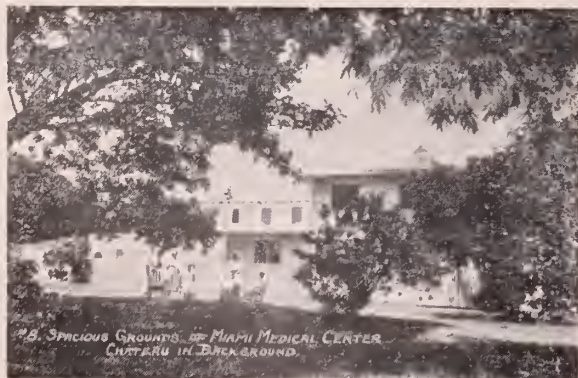
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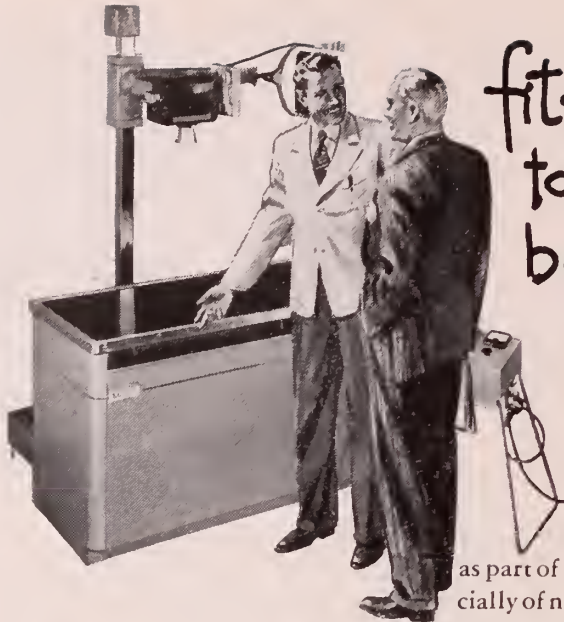
Detailed literature including indications, pharmacology, dosage, and administration is available upon request.



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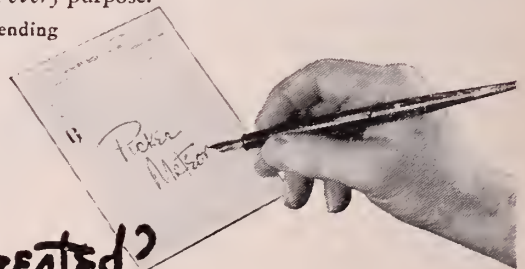
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Faylor W. Griffin, Quincy	Marianna
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochran, Daytona Beach	Ocala
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Ft. Myers
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	West Palm Beach
Florida Specialty Societies			
Allergy Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Heart Association	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Thornton D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewitt, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	W. W. Emmel, D.V.M., Gainesville	Gainesville, June 3, '50
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Dr. W. F. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	November, 1950
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, June 25-27, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 26, '50
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Cannon, Montgomery	Birmingham, Apr. 20-22, '50
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Macon, Apr. 18-21, '50
E. Hospital Conference	Mrs. Jewell Thrasher, Dothan, Ala.	Mr. L. H. Gunter, Montgomery	St. Petersburg, April 5-7, '50
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Atlantic Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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	Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	64	8	
	Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	1	
	Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	13	
	Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
	Columbia Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	47	40	
	Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		7	6	
	Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	1	
	Taylor *Dixie-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	202
B	Alachua Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 331 W. University Ave. Gainesville	Henry H. Graham, M.D. 749 E. Main St., N. Gainesville	2nd Tuesday 8:00 P.M.	43	40	B-3-50 Charles C. Grace, M.D. St. Augustine
	Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	246	142	
	Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	29	23	
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
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	St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	14	13	B-4-51 Cleland D. Cochrane, M.D. Daytona Beach
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	Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	133	105	
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	Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	153	16	C-5-51 M. Crego Smith, M.D. Clearwater
	Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	20	5	
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	Pinellas	Albert R. Frederick, M.D. 408 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	167	163	
	Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	24	4	C-6-50 H. Quillian Jones, M.D. Ft. Myers
	DeSoto-Hardee- Highlands- Charlotte-Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	27	3	
	Lee *Collier, Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	23	21	
	Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	82	56	508
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	St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	12	8	
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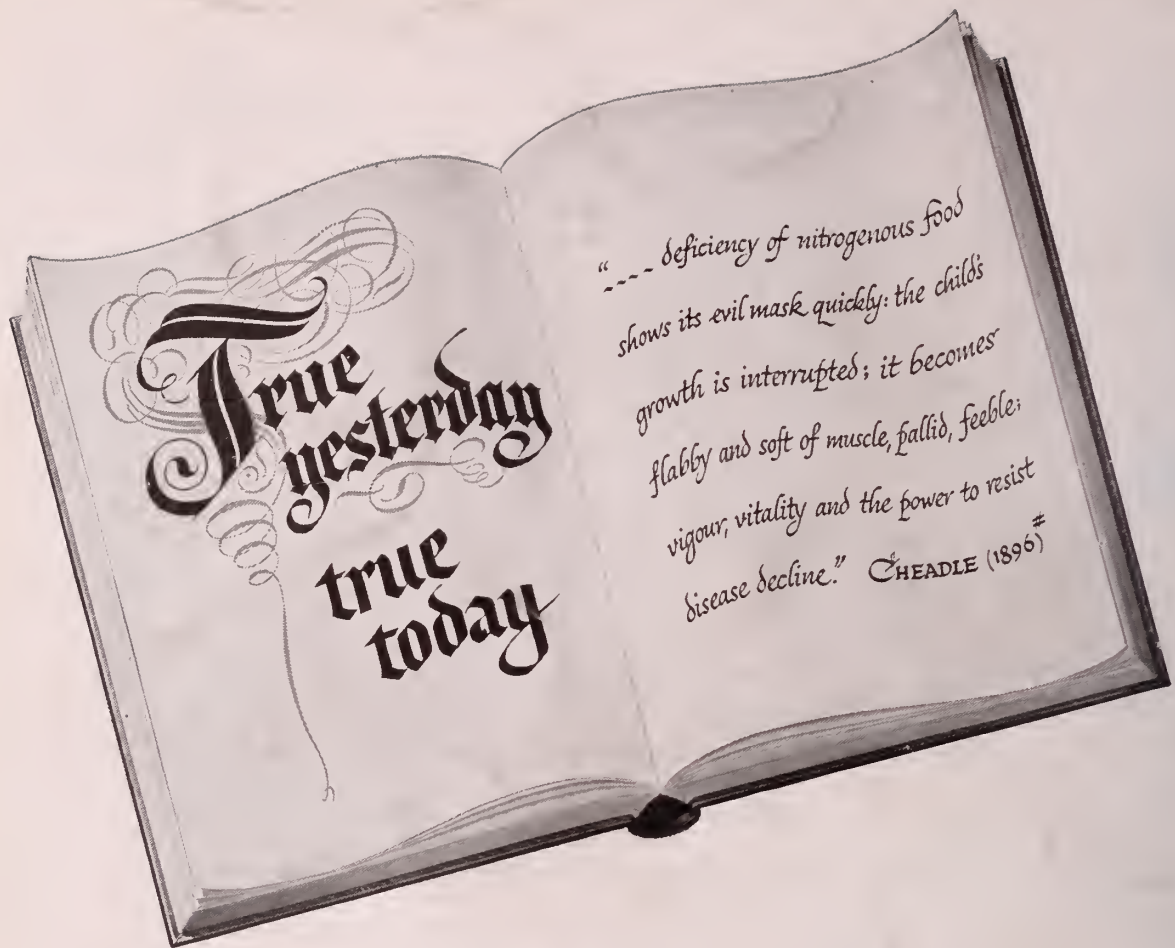


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#Cheadle, W. B.: *Artificial Feeding of Infants*, 1896; Cited by Clements, A. D.: *M. J. Australia* 2:404, 1946.

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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

MAY, 1950

No. 11

IN THIS ISSUE

Changes in Electrocardiogram

David A. Nathan



Laryngeal Paralysis

J. Brown Farrior

R. A. Bagby



Adenoma of Breast

Stanley Frehling

Robert L. Swink




Physician Looks at Government

An Editorial



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* United States Dispensatory 24th edition, 1947.



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Volume XXXVI

MAY, 1950

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CONTENTS

SCIENTIFIC ARTICLES

Changes in the Electrocardiogram in Toxic States, David A. Nathan, M.D.	687
Bilateral Laryngeal Paralysis: Relief of Respiratory Obstruction by Arytenoidectomy, J. Brown Farrior, M.D., and R. A. Bagby, M.D.	692
True Adenoma of the Breast, Stanley Frehling, M.D., and Robert L. Swink, M.D.	694

ABSTRACTS OF MEDICAL ARTICLES

Drs. Joseph W. Scott, Emil M. Isberg, J. Brown Farrior, Elsmere R. Rickard and John P. Michaels	697
---	-----

EDITORIALS

A Physician Looks at His Government	700
Flight Through Space	701
Mr. Ewing's Heap of Beans	702
The Relativity of Health	702

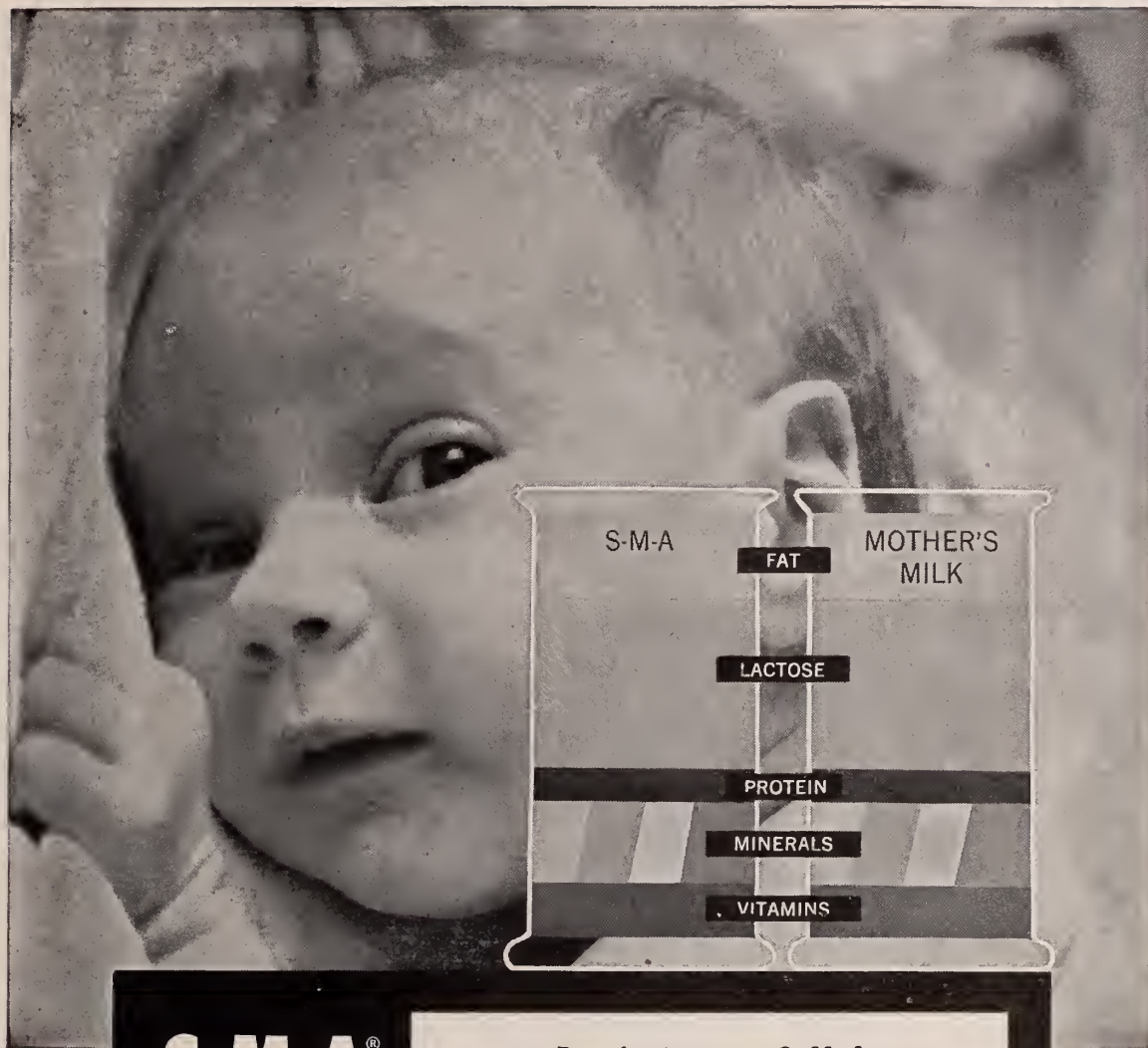
COMMENTARIES

Doctors Are Citizens	703
How Embarrassing	703
Lay Comments on Socialized Medicine	704

GENERAL FEATURES

Officers and Committees	698
Your Blue Shield	704
National Education Campaign	704
Deaths	705
New Members	705
State News Items	705
Component Society Notes	706
Schedule of Meetings	717
List of County Medical Societies, Presidents and Secretaries	718

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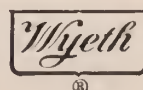
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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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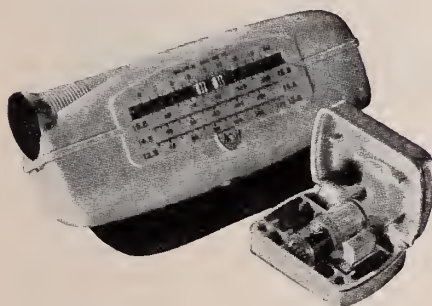
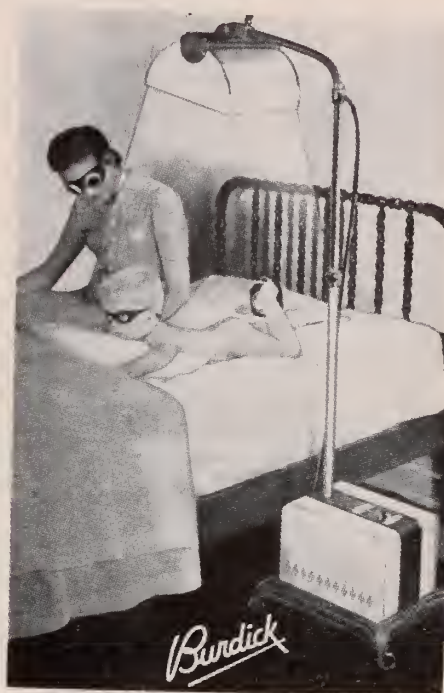
**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-25, No. 11, 590-592; *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, 1937, Vol. XLVII, No. 1, 58-60

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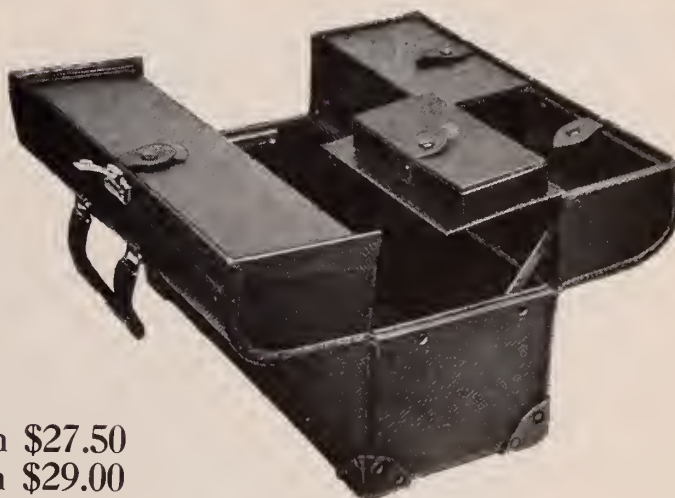


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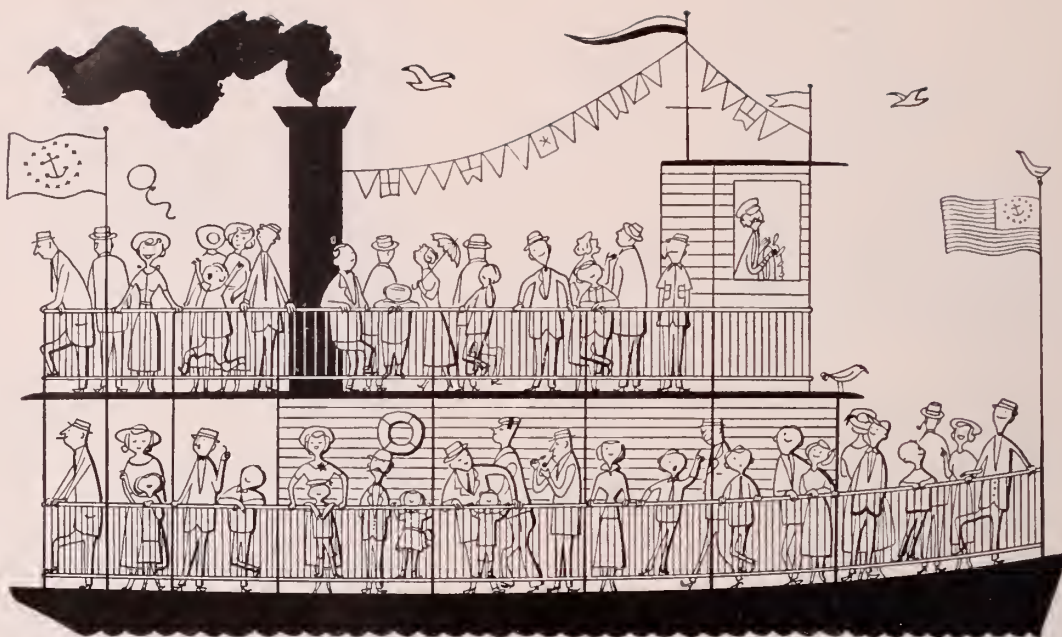


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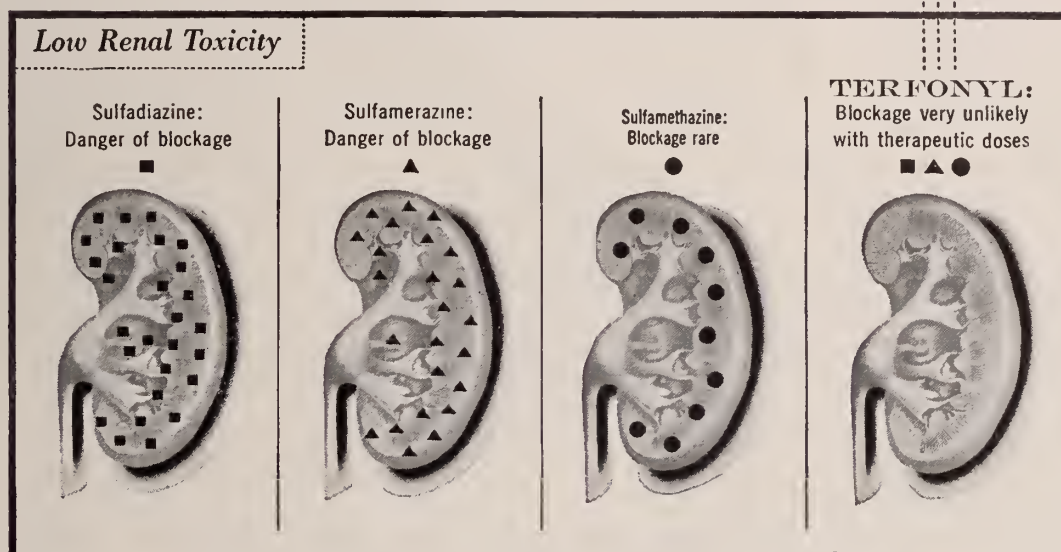
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Changes in the Electrocardiogram in Toxic States

DAVID A. NATHAN, M.D.

MIAMI BEACH

It is generally conceded that toxic states produce certain changes in the electrocardiogram. Master and Jaffe,¹ in 1934, described these changes in typhoid and typhus fever, gonorrheal and rheumatoid arthritis, pulmonary tuberculosis, malaria and lobar pneumonia. They consisted of conduction defects and alterations in the T wave in a rather large percentage of cases. Other writers have stressed the appearance of electrocardiographic changes in the presence of mumps,² infectious hepatitis,³ infectious mononucleosis,⁴ and various other toxic diseases. While factual matter of interest concerning the production of such changes in association with one or more diseases has been presented, few authors have reviewed the subject as a whole to point out that, irrespective of the toxic state, the electrocardiographic changes observed are similar in character.

The time allowed for this paper precludes a comprehensive review of the literature. Such a review doubtless would be of interest, but it would not be particularly instructive. It seemed more desirable, therefore, to consolidate the knowledge of the subject, and it was with this objective in view that this paper was written.

The cases presented are representative ones and cover only a few of the toxic conditions in which electrocardiograms have been made.

Report of Cases

Case 1.—The first report is of a case in which recurrent malaria developed in a patient aged 21 years. Electrocardiograms were made during an exacerbation of chills and fever and after convalescence (fig. 1). T1, T2 and T3 were isoelectric. The P-R interval was .16 sec. Five days later the T waves were normal in leads II and III and more positive in lead I. ST2 and ST3 were elevated 1 mm. above the isoelectric line.

Case 2.—In a case of severe tonsillitis pronounced changes were noted in the electrocardiogram. The electrocardiographic picture was compatible with that of posterior myocardial infarction. Q2 and Q3 were noted with deeply inverted T2 and T3. Four days later T2 and T3 were upright. Q2 and Q3 persisted. The ST2 junction was elevated 1 mm. above the base line.

Case 3.—The electrocardiogram of a patient with lobar pneumonia showed no changes other than those of T wave depression in the limb leads. Three weeks later the electrocardiogram was interpreted as normal.

Case 4.—Low voltage of T1 with sagging of ST1 and ST2 was demonstrated in the electrocardiogram of a patient with bilateral pleural effusion (fig. 2). One day later these changes were not present. T1 and T2 were normal. While the patient was treated with sulfonamides, these drugs were not believed to be a factor in influencing the electrocardiographic tracing. This therapy was administered continuously throughout the illness, and therefore should have affected the tracings similarly.

Case 5.—In a 25 year old man there developed an acute nongonococcal arthritis following an acute urethritis. Early in the illness the electrocardiogram showed that T2 was depressed. The inverted T3 was normal for the patient. After three days T1 decreased in voltage, and T2 was semi-inverted. T4 was poor in voltage. One week later the T waves had returned to normal in all leads.

Case 6.—Three days after the onset of an acute glomerulonephritis, electrocardiographic tracings showed that T1 and T2 were inverted, T3 was isoelectric, and T4 was low in voltage. T1, T2 and T4 increased in negativity with a tendency of ST1 toward coving. This pattern resembled that of anterior myocardial infarction. During convalescence from the acute phase of the illness the electrocardiogram returned to normal.

Case 7.—In an electrocardiogram recorded on a 31 year old man four hours after the ingestion of rat poison⁵ containing 2.5 per cent elemental phosphorus, T2 was flat and T3 was inverted. Four hours after the first electrocardiogram was made (fig. 3a), a second one showed a small T1, an isoelectric T2 and a decreased voltage of T4 (fig. 3b). In the third electrocardiogram taken two days later, T1 was unchanged, but T2 became inverted. There was further decrease in the height of T4 (fig. 3c). The fourth electrocardiogram, taken three days after the one shown in figure 3c, showed coving of the ST segment in leads I, II and IV. The T1 and T2 waves were inverted and the T4 wave was markedly inverted (fig. 4a). Subsequent electrocardiograms showed a return of the T waves to the upright position (figs. 4b and 4c). In this case, as in the previous one of acute glomerulonephritis, the findings resemble those of the T stage of anterior wall infarction.

Case 8.—A man, aged 31 years, was admitted to the hospital with the diagnosis of sunstroke. His temperature was 109°F. In the electrocardiogram, ST1 was depressed. T1 was semi-inverted, while T2, generally poor in voltage, varied somewhat throughout the remaining leads. The P wave fell regularly within .12 sec. of the QRS complex (fig. 5). This tracing resembled that of early posterior myocardial infarction.

Comment

These cases demonstrate the fact that changes in the electrocardiogram are much the same regardless of whether the underlying disease is infec-

Read before the Florida Heart Association, First Annual Meeting, Belleair, April 10, 1949.

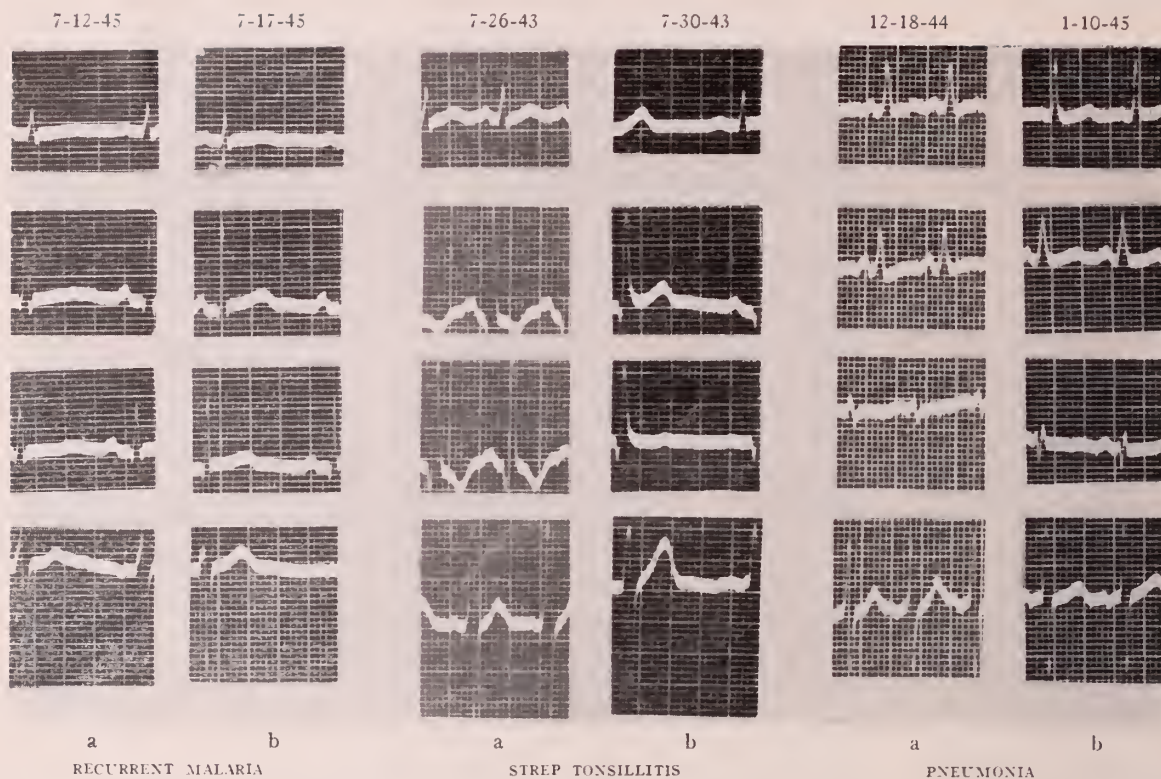


Fig. 1—Toxic changes in the myocardium. Tracings show (a) low voltage or inverted T waves during toxic states; (b) reversion of the T wave to normal.

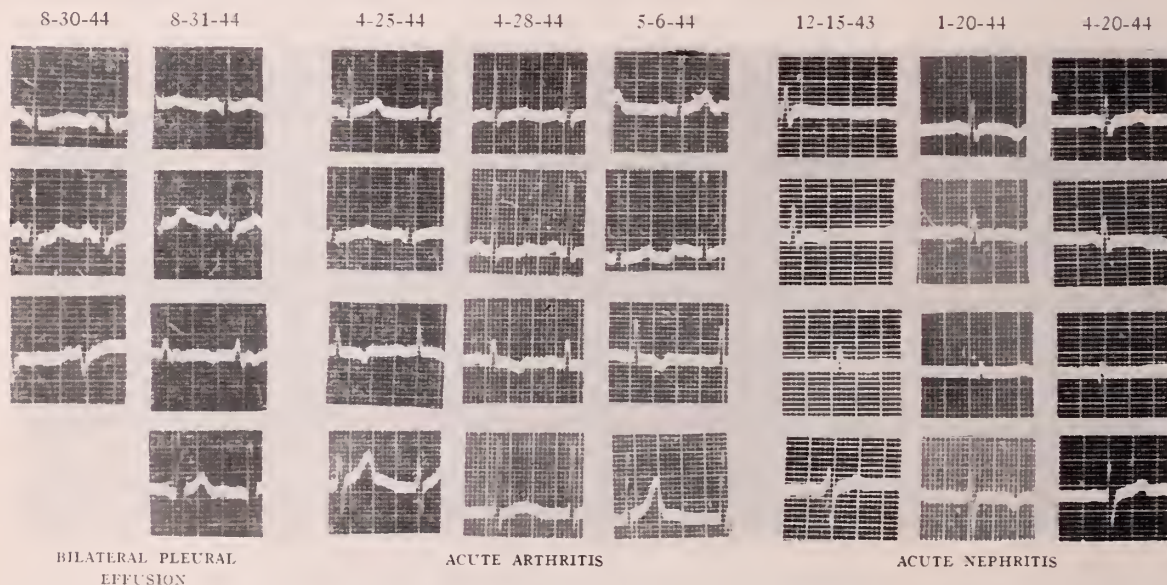


Fig. 2—These tracings illustrate the great influence of toxic states on the T wave, with reversion to normal.

tious, due to poisons or due to thermal influences. In all instances the earliest and most profound change is the effect on the T wave in one or more leads. The change in the T wave may be slight or definitely abnormal, varying from a decrease in the voltage to a deep inversion. Less frequently, sagging or depression of the ST segment may be present. The ST segment may assume the coved characteristic of infarction with the tracing resembling that of anterior or posterior coronary thrombosis.

In a study of 84 patients selected as being free of pre-existing heart disease, who were suffering from a variety of acute infectious diseases, Fine,

Brainard and Sokolow⁶ found abnormalities in 33.3 per cent of the patients studied. These patients were suffering from typhoid, diphtheria, meningococcus meningitis, infections caused by pneumococci and Hemophilus influenzae, pneumococcal pneumonia, acute streptococcal infections and mumps. The most frequent abnormality was an alteration of the T wave. Prolonged P-R interval, prolonged QT interval, arrhythmias, disturbed intraventricular conduction and ST segment abnormalities occurred in descending order of frequency. In a previous study,⁷ I stressed the effect of toxic states on the heart rhythm. A review of the arrhythmias will not be reiterated in this presentation.

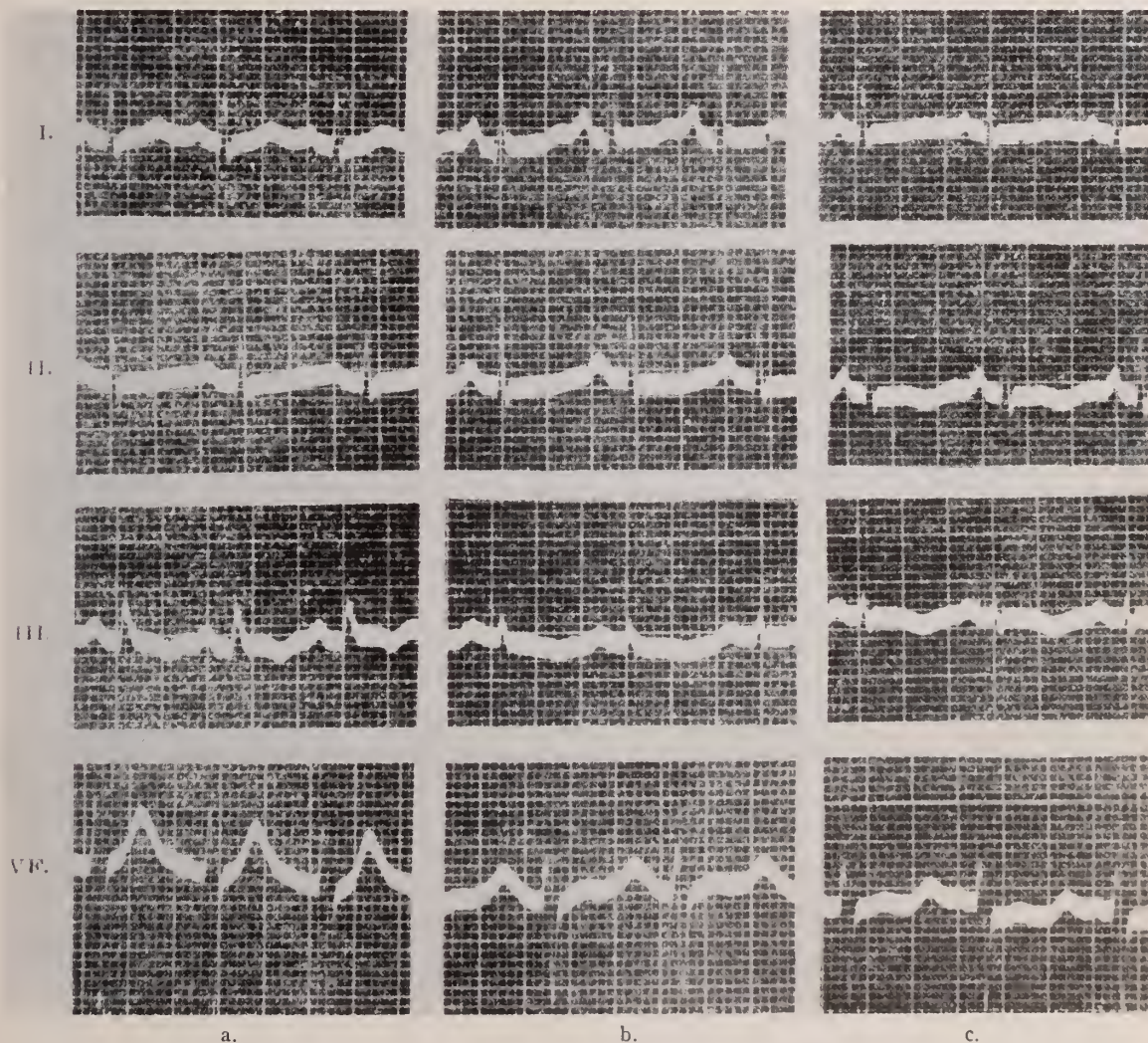


Fig. 3.—(a) Aug. 3, 1944, four hours after ingestion of phosphorus; flat T2, inverted T3. (b) Aug. 4, 1944 twenty hours later; small T1 precedes P1, T2 not discernable, T4 decreased in height, and Q-T duration .56 sec. (c) Aug. 6, 1944; T1 isoelectric, T2 inverted, further decrease in height of T4, and Q-T duration .52 sec.

The frequent occurrence of the changes described has been reported by several other workers. Scherf⁸ found that in 10 to 15 per cent of patients with acute tonsillitis there develop electrocardiographic changes suggesting myocardial involvement. Rantz, Boisvert and Spink⁹ reported electrocardiographic changes in 10.8 per cent of 185 patients due to group A hemolytic streptococcus infections. Rachmilewitz and Braun¹⁰ reported on 50 patients with typhoid fever with electrocardiographic changes in 35. The commonest change occurred in the T wave, which was low, diphasic or inverted. Tarr¹¹ found T wave changes in electrocardiograms of 141 patients with schistosomiasis treated with antimony compounds such as fuadin and tartar emetic. The frequent incidence of T changes, ST segment depression and P-R interval prolongation produced by digitalis is well known. The abnormalities resulting from antimony com-

pounds and digitalis are indistinguishable from those due to infections.

It is of interest in passing that even nontoxic states have been observed to influence changes in repolarization, indicating their action on the electrical activity of the myocardium. Drinking of ice-cold water, smoking and syncope¹² are simple examples which affect the T wave, causing it to become depressed or inverted.

It is apparent that the electrocardiographic changes described have no prognostic significance, regardless of the degree of change present. Greater negativity of the T wave, deeper depression of the ST segment, greater prolongation of the P-R interval, or similarity of the electrocardiogram to that of myocardial infarction, does not aid in the prognosis of any given case. Prognostication depends on the type and severity of the basic disease.

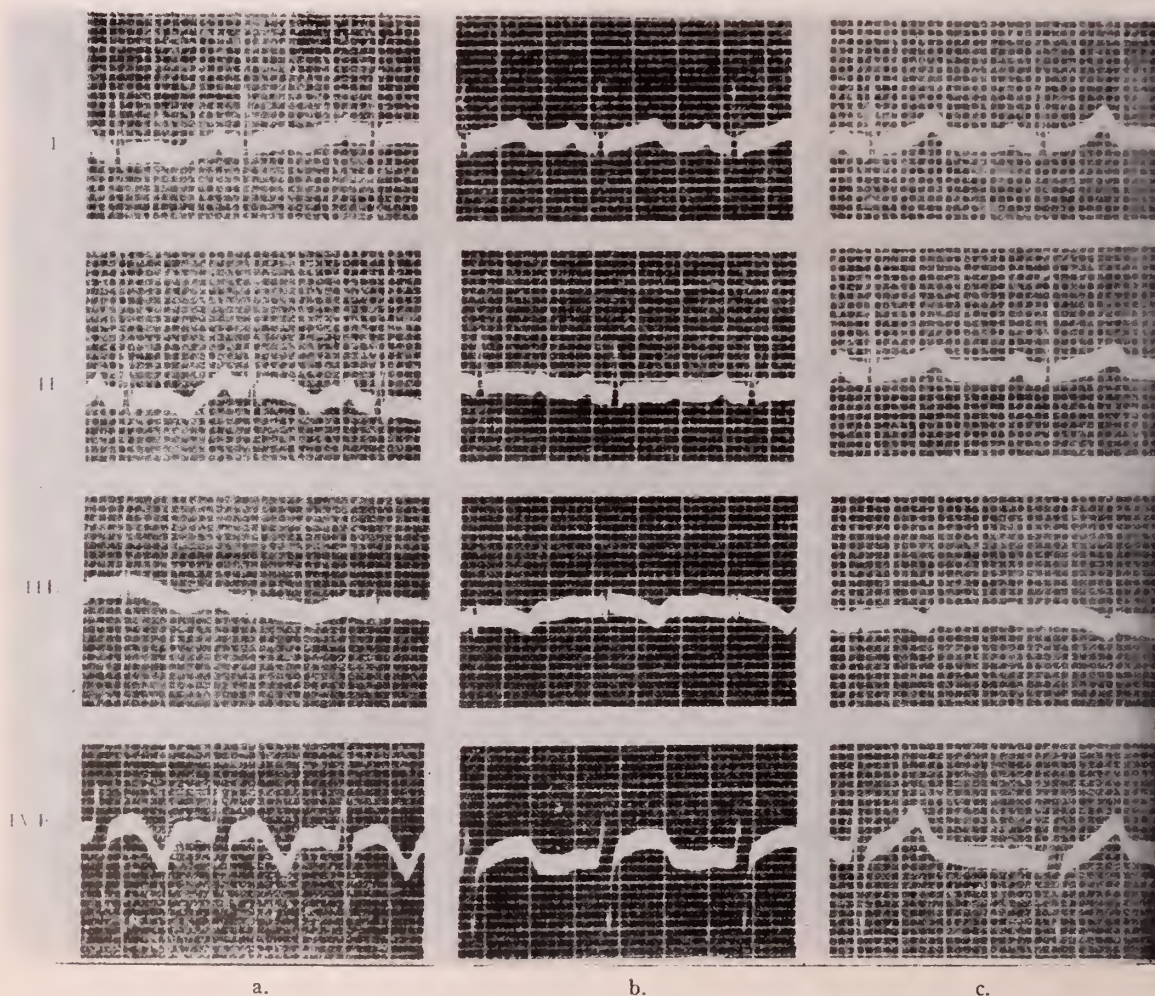


Fig. 4.— (a) Aug. 9, 1944; note coved ST₁, ST₂ and ST₄; T₁, T₂ and T₄ inverted; Q-T duration .36 sec. (b) Aug. 16, 1944; return of T₁, T₂ and T₄ to positivity. (c) Aug. 21, 1944; normal electrocardiogram.

Conclusions

Widely different toxic states influencing the myocardium produce essentially similar electrocardiographic changes or abnormalities. These changes are usually limited to the repolarization phase of the electrical systole with the production of low, isoelectric or inverted T waves.

The ST segment may be depressed or isoelectric with a coving simulating myocardial infarction of either anterior or posterior type. The P-R interval may be prolonged and arrhythmias may be present.

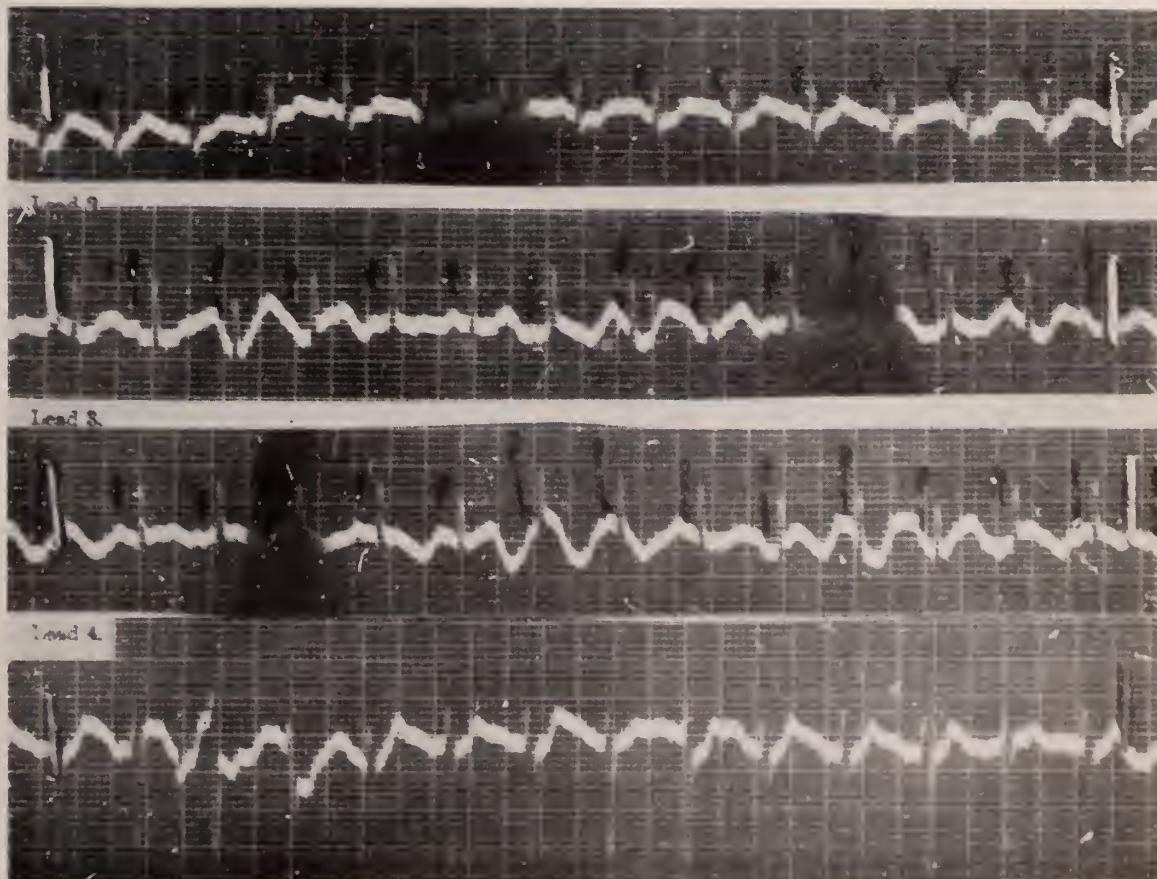
Even if the electrocardiographic changes are severe, the electrocardiogram affords no means of prognosis because, as has been brought out, the changes may be the same for a number of different conditions and may return to normalcy within a brief period.

It is clear from the observations made and the facts known that the prognosis in a given case must be governed altogether by the clinical evidence.

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SUNSTROKE — TOXIC CHANGES

Fig. 5—Note depressed ST1 and semi-inverted T1; there is variation in the contour of T in the remaining leads.

Bilateral Laryngeal Paralysis: Relief of Respiratory Obstruction by Arytenoidectomy

J. BROWN FARRIOR, M.D.

AND

R. A. BAGBY, M.D.

TAMPA

Bilateral abductor paralysis of the larynx results in severe respiratory obstruction. A tracheotomy is usually necessary to maintain life. Until recent years, the patient with bilateral abductor laryngeal paralysis has been condemned to a lifetime tracheostomy.

In bilateral laryngeal paralysis, the vocal cords are held fixed in the midline, producing laryngeal obstruction (fig. 1). The goals of surgical intervention are to relieve the laryngeal obstruction, maintain an adequate airway (fig. 2) and preserve a functional voice.

Older surgical procedures, as removal of the vocal cords, were unsuccessful in maintaining an airway because of resulting cicatricial obstruction. A more adequate and more permanent airway was obtained through the lateral fixation of the vocal cord and the arytenoid cartilage by King^{1,2} and, later, the arytenoidectomy and lateral fixation of the vocal cord by Kelly.³ Woodman^{4a} combined the merits of the King and the Kelly operations and facilitated the surgical procedure through a posterior extralaryngeal approach. In the Woodman operation, the posterior surface of the larynx is approached through an external incision, the arytenoid cartilage is removed, and the vocal cord is sutured laterally to the thyroid cartilage. This laterally fixed vocal cord provides an adequate airway. Woodman^{4b} reported 24 cases treated by this technic. Our case is presented as an addition to this number.

Bilateral abductor paralysis, most frequently resulting from thyroidectomy, is produced by other pathologic causes, as neurosyphilis. The case presented here illustrates the latter cause.

Report of Case

The case history is one of gradual progressive dyspnea, with recurrent attacks of respiratory distress which finally necessitated a tracheotomy. By a Woodman arytenoidectomy, an adequate airway was restored and the trache-

otomy tube removed. The end result is an adequate airway and a useful voice.

Chronologically, the patient was first seen in the Out-patient Department on July 26, 1949; on August 14, a tracheotomy was performed; on September 14, the arytenoidectomy was performed; on September 25, the patient was discharged from the hospital.

At the first examination, the patient complained of progressive dyspnea for ten years. For the last three years, respiratory distress had been so great that he was unable to walk more than short distances without rest. The dyspnea had become so great that he was unable to speak more than two or three syllables at one time. At night, he could sleep only when propped up in bed, and his loud raucous respirations annoyed the neighborhood. Four days prior to his visit to the clinic, there developed a cold which precipitated great respiratory distress.

A complete history and review of systems revealed that the patient had been ataxic for the past several years.

PHYSICAL EXAMINATION.—Laryngoscopic examination revealed that the vocal cords were fixed in the midline with a glottic chink 1 mm. wide (fig. 1). On phonation, there was some tension of the vocal cords; on inspiration, there was no abduction of the vocal cords. Inspiratory movement produced a stridulous flutter of the vocal cords. The gag reflex was moderately reduced.

General examination revealed a thin, well developed Negro man approximately 60 years old. Respiratory distress was great, producing retraction of the suprasternal notch and supraclavicular fossae. The patient was particularly euphoric and cooperative.

Neurologic consultation led to the diagnosis of syphilis of the central nervous system, based upon positive neurologic findings, a positive reaction to the Kolmer test with a mastic curve of 555550000000 and a cell count of 46 lymphocytes in the spinal fluid.

Roentgen examination of the chest showed the heart to be of average size and shape with slight diffuse dilatation of the aorta. The remaining details relative to the physical examination and laboratory studies were without significance relative to the present illness.

PROGRESS.—Upon admission, the patient refused tracheotomy; however, there secondarily developed a respiratory infection which precipitated great respiratory distress, necessitating a tracheotomy on August 14. He made an uneventful recovery and was discharged from the hospital on the eleventh postoperative day, wearing a tracheotomy tube. The care of the tracheotomy tube proved too complex a problem for the patient and his guardian sister. They were unable to make the frequent visits to the clinic for its care. On September 12, therefore, the patient was readmitted to the hospital for the arytenoidectomy.

OPERATION.—On September 14, the Woodman arytenoidectomy was performed under intravenous pentothal sodium anesthesia; this anesthesia was supplemented with 1 per cent novocain locally and 10 per cent cocaine

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Fig. 1.—The preoperative view of the larynx demonstrates the inadequate airway when the cords are held fixed in adduction in bilateral abductor paralysis.



Fig. 2.—The postoperative drawing of the larynx illustrates the adequate airway postoperatively when the left vocal cord is held in abduction by arytenoidectomy and lateral fixation.

topically to the larynx. A left transverse incision was made one third of the way down from the upper edge of the thyroid cartilage. The sternocleidomastoid and omohyoid muscles were exposed. The omohyoid muscle was severed and the sternocleidomastoid muscle retracted, exposing the posterior edge of the thyroid cartilage. A vertical incision was made through the perichondrium along the posterior edge of the thyroid cartilage and the inferior cornu. The perichondrium and inferior constrictor of the pharynx were elevated. The inferior cornu of the cricoid cartilage was dislocated from its articulation with the cricoid cartilage. The perichondrium on the lateral surface of the cricoid cartilage was then dissected upward until the arytenoid cartilage was set free. The muscular process of the arytenoid was then separated. The arytenoid cartilage was removed except for the vocal process. Chromic sutures (0000) were placed submucosally, passing through the fibers of the thyroarytenoid and vocalis muscles. With these sutures, the vocal cord was retracted laterally and the sutures tied around the inferior cornu of the larynx. The lateral retraction of the vocal cord was inspected by direct laryngoscopy, the laryngoscopist assuring that an adequate airway had been obtained (fig. 2). Closure was accomplished by suturing the perichondrium in position and the remainder of the wound in layers. The patient's immediate postoperative condition was excellent.

On the first postoperative day, the patient was up and about the ward, taking a liquid diet without difficulty. The third postoperative day, he was able to eat a regular diet. Indirect laryngoscopy on the fifth postoperative day revealed moderately severe ecchymosis of the left hemilarynx. On the eighth postoperative day, the patient was able to breathe through the larynx without difficulty.

The tracheotomy tube was occluded and finally removed on the eleventh postoperative day, since which time the patient has been followed in the Outpatient Clinic.

RESULT.—Now three months postoperatively, the patient experiences no respiratory difficulty. Laryngoscopy reveals an adequate airway, a glottic chink of 5 mm. at the vocal process. He is able to talk without respiratory difficulty and without limiting his speech. Where preoperatively he was unable to walk more than short distances without rest, he is now able to walk the two miles from his home to the clinic without difficulty.

Summary

The case reported is one of syphilitic bilateral abductor paralysis of the larynx in which restoration of an adequate airway and a functionally useful voice was effected with the Woodman arytenoidectomy.

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True Adenoma of the Breast

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AND

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MIAMI

Adenomas and papillomas are the two types of mature epithelial tumors of the breast. In the adenomatous group, it is the relationship between the epithelium and the concomitant fibrous tissue which determines the type of these tumors. Beneke¹ stated that there are adenomas which more or less imitate the lactating breast, known as pure adenomas, and a much larger group of adenomas which correspond to the nonlactating breast, referred to as fibroadenomas. In the case we are reporting the tumor belongs to the group of pure adenomas.

Report of Case

A Negro woman, aged 37, complained of a lump in the right breast. She stated that she had had a lump in this breast since the time of its development at puberty. The lump had remained small until the past few months when she noticed an increase in size and discomfort. She had some discomfort prior to her monthly menstruation, and the breast became enlarged, but in recent months more pain was associated with the lump in the right breast. There had been secretions from both breasts for years. Hysterectomy had been performed in June 1948 in West Palm Beach because of a fibroid uterus. She was told that both tubes and part of one ovary were removed. There had been no menses since the operation in June 1948, and the last abortion had occurred in April 1948. There had been no full term pregnancies.

Positive physical findings were confined to the breast and abdomen. Both breasts were fully developed with normal erectile nipple. In the upper outer quadrant of the right breast, there was a firm nodule, not tender, not attached to surrounding tissues, and consisting of two lobes about 1 cm. in diameter. No axillary adenopathy was noted. There was a left paramedian scar on the abdomen, but no tenderness nor masses were noted.

Under general anesthesia the lump was removed from the right breast via radial incision.

Pathologic Description. Gross: The specimen consisted of an ovoid-shaped, well encapsulated tumor, rubbery-like in consistency. It measured $3\frac{1}{2}$ by 3 by 3 cm. Cross section revealed the capsule to be about 1 to $1\frac{1}{2}$ mm. in thickness and to be white in color. The surface of the tumor was smooth; the tumor itself had a peculiar yellowish brown color, was soft and contained small cysts measuring up to 2 mm. in diameter. It could be noted that the tumor was subdivided into irregularly shaped islands of different sizes separated from each other by a network of connective tissue which could be traced in some instances toward the capsule.

Microscopic: A section of the tumor stained with

hematoxylin-eosin was covered by an extremely broad band of connective tissue. This connective tissue had within it small islands of fatty tissue and small islands of normal as well as pathologic breast tissue. The latter exhibited a laminated increase in connective tissue bulging into hyperplastic ducts which were transformed into fissure-like formations irregular in shape, this change being compatible with a small intracanalicular fibroadenoma.

The tumor was adjacent to the area described, and three types of acinar architecture were seen: (1) acini of a small caliber with or without secretion packed back to back, (2) larger acini with evidence of a considerable amount of secretion and (3) cystlike cavernomatous areas showing large amounts of secreted material. The interstitial tissue varied. It was sparse in areas of the small acini that were arranged back to back and increased in amount until the connective tissue was rather dense between the large acini.

With the use of mucicarmine stain, the secretions accepted the characteristic red color in some areas within the lumen but not within the cytoplasm. After using the Shorr stain, the secretions had two elements which could not be identified as to their chemical composition. One was homogeneous and greenish in aspect; the other brown and more of a droplet-like material. These droplets had a tendency to be confluent and to block the acini in the form of huge dark brown plugs. The Shorr stain also showed the brownish secretions with the cytoplasm.

The Shorr stain on permanent sections, used liberally in the Department of Pathology of Jackson Memorial Hospital by Dr. Philipp R. Rezek, Director,³ is based on the publications of Shorr² and Papanicolaou³ respectively, in reference to smear studies on the female human vagina and Rhesus monkey vagina.

We found this stain especially valuable in our routine histologic preparations on permanent slides. We not only obtained proper staining of cytoplasm, nuclei and nucleoli but simultaneously were able to see a delicate but distinct connective tissue, as well as secretion granules of different origin with the exception of mucin.

Concerning the technic, we should like to make this preliminary statement: Sections were prepared like the ordinary hematoxylin-eosin stain regardless of previous fixation, but instead of staining with hematoxylin-eosin, we used the Shorr stain. The latter was applied in the same way, as far as time and technic are concerned, as it is used for the smear technic. Following staining, alcohol, xylol, terpineol and balsam were applied in the usual manner. In the near future, a separate paper will be issued from this department with reference to the special technic on normal and pathologic tissues of human material.

Heidenhain's iron hematoxylin stain was used for study of the cell structure. The small acini of previously described areas were outlined by either a single or double layer of cells. The acini, composed of two layers, showed the cells to be the low columnar and the myoepithelial types. The nuclei were more or less round and sharply outlined. The nucleoli were normal in size. A distinct cuticulum separated the cells from the lumen. There was nowhere evidence of malignant disease.

Diagnosis: Pure adenoma of the breast.

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Discussion

The adenoma purum or pure adenoma is a benign epithelial tumor which imitates more or less the architecture of the lactating breast and which nearly always exhibits some sort of secretion in the form of colostrum or even milk. According to a few authorities (Chalatow⁴ and Cheatle^{5a}), a pure adenoma assumes a special position among the tumors of the breast. Another group of authors such as Aschoff,⁶ Deaver and MacFarland,⁷ de Cholnoky,⁸ Geschickter,⁹ and Oliver and Major¹⁰ considered this tumor to be a variety of fibroadenoma. Foot¹¹ considered it an acinar adenoma and a type of breast lesion which he believed decidedly rare.

It is considered to occur rarely, but does so more frequently than indicated in the literature. Until 1933, reports of only 40 cases could be found which stated that the distending glands of the tumor imitate the architecture of a lactating breast. Since that time, most of the authors have regarded this tumor as a variety of fibroadenoma and, therefore, no accurate number of reported cases can be given.

The pure adenoma is rarely observed during puberty;¹²⁻¹⁴ most frequently it occurs in pregnancy. Often the tumor is noted during the first month of pregnancy^{5a, 15-19}. In several cases it antedated pregnancy, increased during gestation and enlarged even more during lactation^{5b, 14, 20-23}. To our knowledge, there has never been a case reported in a male.

In most cases the tumor is a cherry to walnut size mass, rarely attaining the size of a chicken egg.²⁴ It is well encapsulated, freely moveable, does not infiltrate the surrounding tissue, and generally is not tender to palpation. Grossly, the mass resembles a lactating breast, salivary gland or pancreas. The cut surface varies from grayish yellow to grayish red in color. It is slightly transparent, and by scratching the surface one may obtain granules. Delicate strands of white connective tissue subdivide the tumor into smaller lobules.^{15, 22} Bothe²¹ stated that the cut surface may show a thick creamlike liquid similar to condensed milk. Others^{7, 24-29} described smaller or larger cystlike formations filled with a creamlike or watery fluid which sometimes smells like sour cream. In our case, the cysts varied in size from .8 mm. to 2 mm. and some contained a clear, viscid material, others a watery, milklike material.

The histologic appearance of a pure adenoma consists almost entirely of distended glands sep-

arated from each other by delicate septums. The capsule surrounding this highly glandular mass is easily discernible. The tumor looks like a lactating breast, and for that reason, Schmauss and Herxheimer²⁰ referred to it as acinus adenoma. The lobules and acini are larger than those in the surrounding normal breast.¹⁵ Between the acini there is, in addition to the vascular capillaries, only a sparse amount of connective tissue fibrils, and so the acini give the appearance of being arranged back to back. Cornil¹³ pointed out that pure adenomas which occur during puberty do not differ microscopically from those obtained from a lactating breast if one disregards the presence of the se-

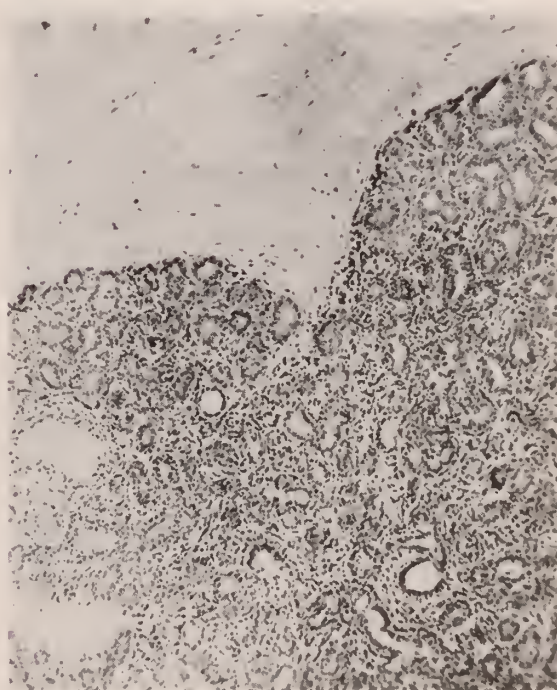


Fig. 1.—Survey of tumor showing well formed capsule. H. and E. x 75.

cretions in the latter case. Accordingly, tumors removed during different periods of pregnancy have secretions which correspond to the particular phases of gestation. The pure adenoma can easily be distinguished from a lactating breast in that it is a well encapsulated tumor and not a diffuse enlargement of the breast.

During pregnancy, therefore, or during the puerperium, one will find the formation of colostrum,^{16, 17} while during the period of lactation one may notice the formation of true milk.^{24, 29} Our case seems to bear little, if any, relationship to pregnancy as the patient was subjected to hysterectomy and partial oophorectomy in June 1948.

She stated that two months prior to that operation she had had a "miscarriage." Since she related that the lump in the breast began at puberty but only became troublesome following the operation in June 1948, we are unable to show any relationship between the tumor and the miscarriage.

The membrana propria is well preserved, and the epithelium of the acini, like in the normal, is arranged in two rows. Kaufmann,³¹ Kudji,³² and Pavie¹¹ stated that the myoepithelial cells and the row of low columnar glandular cells are not dis-

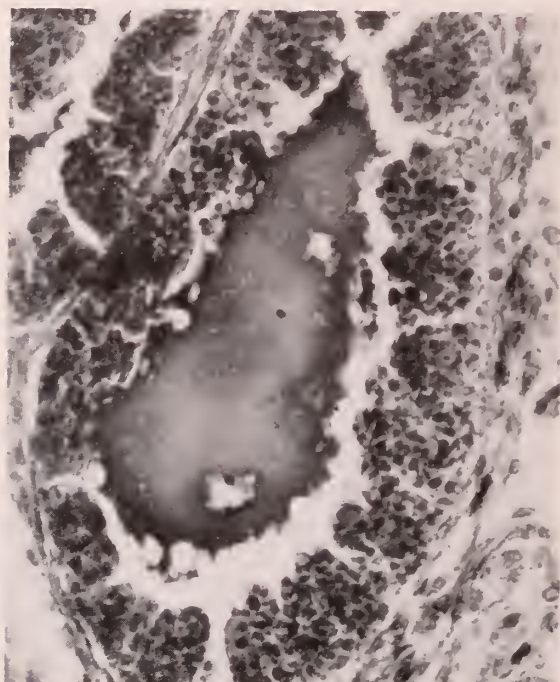


Fig. 2.—Secretions within the epithelial cells. Shorr Stain. $\times 220$.

tinct. Kaufmann³¹ reported that the amount of connective tissue can vary. Deaver and MacFarland,⁷ Kudji,³² and Kilgore³³ showed the presence of mast cells within the connective tissue. In our case, we found microscopically one intracanalicular fibroadenoma which showed no relationship to the adenoma.

Treatment is by simple excision. The method of approach to the mass may be by radial incision or by incision along the inferior border of the breast.

We believe that regardless of how one classifies this tumor, its rarity cannot be overlooked. This is the first case in a ten year span at the Jackson Memorial Hospital. In our opinion, the true adenoma fits the acinus adenoma group of Foot¹¹ and is not a tumor of the canalicular type which includes the frequently encountered fibroadenoma.

Summary

A case of unusual adenoma of the breast is presented. The histologic and gross aspects are described. Also, the classification and incidence of this lesion are discussed.

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ABSTRACTS OF MEDICAL ARTICLES

PROLONGED LABOR, WITH SPECIAL REFERENCE TO POSTPARTUM HEMORRHAGE. By L. D. Odell, M.D., J. H. Randall, M.D., and J. W. Scott, M.D. J. A. M. A. 133:735-738 (March 15) 1947.

In this study of 422 prolonged labors among 15,824 consecutive deliveries, uterine inertia was the principal cause of the prolongation, cephalopelvic disproportion and abnormal fetal presentation accounting for only 13.5 per cent of the cases. Uterine contraction and retraction, these authors observed, are vitally concerned with the length of labor, with spontaneous placental separation and with the physiologic control of bleeding from the puerperal uterus.

Postpartum hemorrhage in this series was more frequent following prolonged labor. This increased tendency toward abnormal loss of blood was due largely to prolonged anesthesia and the trauma of operative delivery, but after nonoperative deliveries was on the basis of postpartum uterine atony. Astute anticipation of this tendency to bleeding, with careful conduct of the third stage, early uterine massage and exhibition of oxytocic drugs, as well as the liberal and early use of fluids and whole blood when abnormal loss of blood occurs, is recommended for the prevention and control of hemorrhage and shock.

SOME ASPECTS OF HYPERTENSIVE DISEASE OF PREGNANCY TREATED BY SPLANCHNICECTOMY. By MAX M. PEET, M.D., and Emil M. Isberg, M.D., Am. J. M. Sc. 217:530-538 (May) 1949.

In this investigation of the relationship of the operation of splanchnicectomy to hypertensive disease of pregnancy, a series of cases was studied in which 28 hypertensive women treated by splanchnicectomy subsequently experienced 34 pregnancies. Of 18 who began pregnancy with normal blood pressures, 17 gave birth to 18 infants, and 15 were still maintaining normal blood pressure levels at a recent examination, averaging 2.7 years since delivery and 6.3 years since operation. Of 10 who started pregnancies with blood pressure levels above 150/90, only 2 delivered living infants at term. In not 1 of the 18 patients who re-

sponded to splanchnicectomy by maintaining normal blood pressure levels after operation and who subsequently became pregnant did a toxemia of pregnancy develop. Also, no splanchnicectomized patient suffered any late, harmful vascular effects as the result of pregnancy.

It is concluded that when hypertensive women are divided into two groups depending upon whether or not the hypertension had its origin during a pregnancy, there is little variance in the disease pictures, but there is significant difference in the over-all response to splanchnicectomy. Both groups respond well to the operation, but the end results are definitely better for the women whose hypertensive state began in a pregnancy. The authors advise the young hypertensive woman who wishes to have children to have the essential hypertension treated first by splanchnicectomy. Then if normal blood pressure levels are maintained for a year after operation, she may with reasonable safety become pregnant and with the assurance that her chances are excellent for giving birth to a normal infant.

THE FENESTRATION OPERATION — INDICATIONS, TECHNIQUE AND RESULTS. By J. Brown Farrior. Laryngoscope 59:515-539 (May) 1949.

The author discusses otosclerosis under the classification of early, moderate, moderately severe and severe otosclerosis and states that the fenestration operation is indicated in moderate or moderately severe states of this disease. The technic of the surgical procedure and also of home aural rehabilitation to aid the fenestrated patient is described.

Persistent otorrhea is regarded as the greatest single nuisance factor in fenestration surgery, and the primary skin graft of the fenestration cavity is advocated to facilitate primary healing.

It is concluded that in properly selected patients, a properly performed fenestration operation is relatively free from any serious risk, the operation is usually successful, and the hearing is usually maintained.

ANTIBODY RESPONSE TO VACCINATION AGAINST MURINE TYPHUS. By John P. Fox, E. R. Rickard, James van der Scheer and Herald R. Cox. *Am. J. Hygiene* 49:321-339 (May) 1949.

In this study of the serologic response of more than 400 persons to various methods of primary immunization with murine typhus vaccine of the yolk-sac type, the principal objective was the determination of the optimum method. The results obtained with a single, adequate dose of fluid vaccine in original or in concentrated form closely approximated those obtained by the best of the methods employing multiple inoculations. The use of alum-precipitated or zinc-precipitated vaccines was associated with an inferior response, but inoculation of vaccine in the form of a water-in-oil emulsion resulted in immunity of more prolonged duration.

ACUTE IDIOPATHIC PORPHYRIA. By John P. Michaels, M.D., *South. M. J.* 42:965-967 (Nov.) 1949.

A case demonstrating the classical picture of acute porphyria is presented to direct attention to the more common manifestations of this condition, which are neglected in medical teaching and unfamiliar to many physicians. The family history of many interesting hereditary diseases, including 2 probable cases of this disease, further demonstrates the fact that the condition is in all probability a hereditary inborn error of metabolism. Three major surgical procedures had been done, none of which alleviated the symptoms. It is concluded that the mild acute attack was precipitated in this instance by a large dose of some barbiturate.

NOTICE

Old officers and committeemen appear in this May Journal since it went to press before the election of officers in the House of Delegates, April 26.

New officers and committeemen will appear in your June Journal. This same schedule applies to the personnel of the Journal staff.

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NOTICE

Old officers and committeemen appear in this May Journal since it went to press before the election of officers in the House of Delegates, April 26.

New officers and committeemen will appear in your June Journal. This same schedule applies to the personnel of the Journal staff.

A Physician Looks at His Government

Physicians are considered notoriously poor business men. When, one might ask, does a physician have time to study business events and to examine social and economic trends? How can a physician hope to carry on a busy practice, keep up with the multitudinous advances in his profession and yet keep abreast of the broader aspects?

A history of the medical profession shows at a glance that physicians as a whole have been alert, public-minded citizens and leaders through the ages. Today, it would seem wise to pursue the policy of public-mindedness further in an attempt to understand the over-all pattern of trends in government of which compulsory health insurance and socialized medicine are an integral part.

Let us consider three major policies of our present government in Washington and deal with them in short order: 1. Farm surpluses and government support of farm prices. 2. Prosecution of big business. 3. Federal aid to local schools.

1. The government today is collecting hundreds of millions of dollars from taxpayers in order

to support prices of surplus farm stuff. Most of this cannot be sold; so it is stored, and some of it spoils. In order to obtain the products, the government uses the consumer's tax money to outbid the consumer and make him pay more for it. The consumer pays taxes to keep the groceries which he consumes at a higher price. Why? Is it because this is a hangover from the war and early postwar periods to keep prices up so that the farmers would raise more? It would appear that this policy has lingered on and on. No one in government has apparently had the courage to put sharp restrictions on planting where they are necessary; hence, in many instances, a veritable racket has developed whereby the farmer raises all he can and dumps his surplus on the government.

2. Prosecution of big business as a major policy has its peculiar aspects. Why should we follow the reasoning that bigness in business is necessarily bad? Perhaps we can deal with this question simply by asking another. If big business is bad, how about big government? Many thinking people believe today that our government is far too big and has far too great a hold over the individual's liberties — and, paradoxically enough, here is big government prosecuting big business because it is too big.

3. Federal aid to local schools appears to start out quite innocently, but in any system abuses appear, and that is where government steps in — to clear up the abuses. More abuses loom on the horizon, more control is applied, and soon we are

a few short steps away from federal control of education — the worst abuse of all.

The physician likes to reflect that our country was founded on rugged individualism, whereby the man who wanted to get ahead had that opportunity through hard work. It is distressing to him to see how slothfulness is being promoted through a plan of socialism and protection.

Some of our confused leaders would have us believe that free human enterprise is opposed to progress for human welfare. That is not true. Individual economy is essential to true social security. In England, the people have been promised security from the cradle to the grave; yet never have they felt or actually been more insecure. A government cannot honestly promise security to its people when that government is financially insolvent. Most children of high school age can see that if the government gives something for nothing long enough, the result will be insolvency.

Flight Through Space Aviation Medicine's Problem

Even in this mechanically minded age, flight through space intrigues the imagination. Too, at the outset this latest scientific project poses prodigious problems for aviation medicine. Nevertheless, plans are in the making today not only for flights to Mars but also, more immediately, for planes that will fly at 100,000 feet, under conditions approximating those of interstellar space, and perhaps reach Paris from New York in less than an hour.

Space begins, of course, some 10,000 to 15,000 miles up. Engineers must design craft for space flight to meet the needs of the crews that will man them. Space medicine must therefore anticipate the probable human elements involved and determine, so far as possible, these requirements.

"In spite of scoffers, space flight is nearly here, and we've got to be ready for it," recently declared Brig. Gen. Harry G. Armstrong,¹ commandant of the United States Air Force School of Aviation Medicine. Such problems as climatizing space ships, eliminating expired carbon dioxide, water vapor and body wastes, and maintaining a comfortable temperature are already solved. Provision for oxygen would be comparatively simple, for only perhaps half a ton would be required for each man on a trip to Mars and back.

But how would man compensate for the absence of gravity? With muscular strength and

sensomotor nervous system no longer adapted to terrestrial gravitational pull, the space traveler would be literally weightless. Since without weight he could no longer use his power and pressure senses, the remaining sensory nerves would have to suffice to carry out well controlled movements of the limbs. Body movements as a whole would take the form of floating through air. Orientation in space would depend entirely on vision; for example, appearances alone would tell a space flier when he is upside down in relation to the ship. Whether or not man can adjust to a solely optical orientation is not yet fully determined.

Weightlessness would mean lesser demands on bodily activities. Investigators believe metabolism would probably slow down to the basal rate; the heart might slow down somewhat and breathing become shallower because less oxygen is needed; less food would be eaten than normally because of decreased expenditure of energy; indeed, enforced exercise might be necessary to keep muscles from atrophying. To exercise or sit reading, the space flier would probably have to chain himself to the wall lest most any movement send him wafting through the ship's air, and for the same reason his bed would be a semicircular trough, upholstered and covered with strong netting or straps. Without weight to keep liquid in a cup or food in place uncontained, special devices for eating would be required.

How would human reactions and thinking adapt to incredible speed? Could the space flier's brain think fast enough to cope with the speed of the ship? Space medicine scientists do not know yet. Then there is the matter of a whole new set of physiologic adaptations awaiting the space traveler who finally reaches Mars. These scientists believe space flights to Mars would be of great value to science, providing possibly a new era for geologists, botanists, biologists, astronomers and meteorologists. Weather forecasting and even control, they claim, would be practically infallible from space, for there weather processes could be completely followed from beginning to end.

So medicine pioneers the way. And in this land of free enterprise and individual initiative, there will ever be adventurous spirits who will at the proper time volunteer to sally forth into space intent on cracking the secrets of the universe. Who knows but that they may learn how it is that the morning stars sing together?

¹ In the Wild Space Yonder, Newsweek, July 25, 1949, pp. 40-42.

Mr. Ewing's Heap of Beans

Under his proposed compulsory tax on health Mr. Ewing has said often that there will be absolutely no change in the relationship between the patient and the doctor, except that the benevolent government will pay the bill. He also assures us: "The maximum payment that anyone will have to meet is \$1.40 per week — in addition to a like amount by his employer."¹ The implication is that the cost of his dream of regimenting the American people under his compulsory plan would be very economical.

Let us look at Ewing's own figures. Nobody can deny that government's "maximum limits" on charges of any kind automatically become minimum. Remember O.P.A. ceilings on rents and prices of commodities? Who ever heard of getting anything under the maximum government-set cost? On the other hand, government taxes go up, seldom, if ever, down. The \$1.40 per week, matched by an equal amount from the employer, will soon become a minimum rather than a maximum "tax on health." Even the most ardent defenders of the crazy idea admit it will probably go much higher. With unusual candor they admit — knowing surely the wasteful ways of government — that this tax will not cover the whole cost. More will be taken also from "general revenue funds" to maintain "Ewing's folly."

But let us assume, for the sake of discussion, that a miracle could happen and Ewing's figures would really be definitely set as the maximum and the only cost. One dollar and forty cents from employe and employer, each, means \$2.80 per week. This sum in fifty-two weeks amounts to \$145.60, well over \$12 per month per family! Where is the economy or the saving there for anybody, Mr. Ewing? Not even the most luxuriously comprehensive voluntary medical insurance plan under our present competitive and free system reaches one-half the cost of this absurdity.

It is true that Mr. Ewing wants to include free eyeglasses and corsets and even wigs, as in the discredited British plan, as part of his vote-getting-bait scheme. "Its cost does not amount to a heap of beans," he said in New York recently. The trouble is that the heaps of beans, and of dried eggs, and of rotting potatoes, and of staling butter, and of other things that our "paternalistic" politicians are buying with the poor taxpayers' money, so that they can keep various groups of organized voters happy, are growing into tremendous mountains. They are making the cost of government so

high that, if this tendency remains unchecked, true democratic government cannot subsist and shall eventually be crowded out by more and more compulsions, growing rapidly into another and more tyrannical form of despotism.

We don't want to buy your "heap of beans," Mr. Ewing.

¹Radio broadcast "Town Meeting of the Air," Feb. 22, 1949.

The Relativity of Health

For centuries doctors have been indoctrinated with the concept that the primary functions of the physician are to discover, identify and treat disease. The inadequacy of this attitude is apparent today, and to perpetuate it is to retard the progress of medical science and practice.

Health is by no means the mere absence of disease. Being relative, it can always be improved. While no one attains truly ideal health, perfection in health, like infinity, is nevertheless approachable. The potentialities of a healthy, vigorous and mature mankind, largely unexplored as yet, are nevertheless obviously immense.

Perhaps geriatric medicine more than any other area of medical practice emphasizes the relativity of health. In later maturity, responsibility for health rests first and foremost upon aging persons themselves. Medical science and practice can give health to no one, nor can medical service schemes, no matter how paternalistically conceived and executed. Health, like respect, must be earned. Nevertheless, there rests upon medical science and practice the responsibility to discover the causative factors responsible for premature depreciation and the means of their prevention. Also, there is the obligation to guide and advise those who endeavor to keep well.

By focusing their concern upon the construction of greater health of the individual as a whole, rather than merely upon the amelioration of some disorder, clinicians might well enhance tremendously their therapeutic and preventive accomplishments. The physician-patient relationship, in all its individual, personal aspects, has a role in constructing health that has long been neglected. Even with the broader concepts of today, there is great need for better comprehension of the positive meaning of health and for clinical methods of evaluation and measurement of health, as contrasted with the identification of disease.

Doctors Are Citizens

In response to requests from many members who wish to participate in Congressional elections as responsible citizens a brief summary of what a doctor may or may not do, under the law, has been prepared and mailed to each member. This pamphlet, entitled "Doctors Are Citizens," explains in simple language to what extent an individual citizen may go in helping to elect to public office men with whose governmental philosophy he can agree. It also makes clear the limitations placed upon medical societies, whether incorporated or not, in engaging in political activities.

This material has been prepared from an interpretation of pertinent federal laws — particularly the Hatch Act, the Corrupt Practices Act and the New Criminal Code — by the Chicago law firm of Kirkland, Fleming, Green, Martin and Ellis at the request of the American Medical Association, National Education Campaign Committee.

"For all practical purposes, the American people are going to ballot on this issue (compulsory health insurance) at the Congressional elections all over the nation." This statement was made by Mr. Clem Whitaker, Director of the A.M.A. National Education Campaign. The occasion was the second annual campaign conference recently held in Chicago. At that time Mr. Whitaker made available the information relating to the legal aspects of doctors' political activities. Representatives from the state and territorial medical societies carried it home. Florida was well represented by Dr. Joseph S. Stewart, chairman of the public relations committee, president Walter C. Payne, secretary-treasurer Robert B. McIver and Mr. Wm. Harold Parham, supervisor of the Bureau of Public Relations.

On March 19 the second conference of the state education campaign was held in Jacksonville. Speaking to the representatives of the county societies Dr. Louis Orr passed on the information as to the do's and don'ts of participation in election campaigns. He presented a boiled-down version which later appeared in pamphlet form as "Doctors Are Citizens," and which has been distributed throughout the nation and to our territorial possessions by Whitaker and Baxter. It has gone out under the authority of the Board of Governors of the Florida Medical Association.

Doctor, the issue between governmental control and the free practice of medicine is clear cut. You

have the same rights and privileges as other citizens. Fulfil your duty to yourself, your profession and your country by helping to send to Congress the men who you believe will exert every effort to preserve our precious heritage. Read your copy of "Doctors Are Citizens" and be guided by expert opinion as to whether your activities are within the law.

How Embarrassing

Just the other day, Oscar Ewing, the federal security administrator, found himself obliged to announce that the infant mortality rate had dropped to an all time low in 1948, when only 32 of every 1,000 babies died during their first year. The rate in 1930 was 64.6, and in 1940 it was 47. With only half as many dying in 1948 as in 1930, it is predicted that compilation of the statistics for 1949 will show even greater reduction.

A second announcement within two days from government offices provided further significant evidence of the quality of medical care available to the American public. The United States Public Health Service reported that the average life span for men and women, based on 1948 death rates, is at a record high. For white women it is 71 years and for white men, 65.5; for nonwhites it is 62.5 for women and 58.1 for men.

It was only a month or two ago that the office of vital statistics reported the average life span of all Americans as 67.2 years, another record. Furthermore, about the same time Mr. Ewing was required to report that the progress of medical science in the fight against communicable disease has brought the nation's death rate to the lowest point in history, 9.9 for each 1,000 population.

Surely it is passing strange to find Mr. Ewing and the agencies he directs reporting so optimistically on these health problems and telling the American people how hale they remain after entering the ranks of the elderly. When he is not under the embarrassing necessity of citing facts and figures, the security administrator appears to spend most of his time endeavoring to persuade the people that the one and only sure cure for what ails them is socialized medicine, under his supervision. It is singular, to say the least, that the indefatigable administrator keeps piling up more evidence all the time against his own case.

Lay Comments on Socialized Medicine

A No. 1 morale builder came to Dr. Ernest E. Irons, President of the American Medical Association, recently in the form of a letter from a Chicago layman. Dr. Irons commented that reading it made one suddenly aware of a fresh breeze blowing through tired brain cells. This heartening message follows:

"I cannot put M.D. after my name but I can, at least for a while, still put U.S.A. As a consequence, please accept the enclosed check for \$25 as a slight token of regard for my doctor and all his colleagues. These are my 'dues' as a citizen, and I hope they will help in your fight against socialized medicine.

"A people without guts are soon a nation without guts, and if it should become necessary to remove any part of mine, I want to pick my man and pay his charge without a precinct captain getting his nose in my anatomy."

From across the Atlantic there came to an A.M.A. staff member through philatelic correspondence early this year the following comment from an architect surveyor in Leicester, England:

"I think the idea of yours regarding the Fildes reproduction on your envelopes is a great scheme, and I am so pleased to think you are putting up a fight against socialized medicine. We are well in it. The whole scheme is rotten to the core and should be repealed. In this country it is a fearful flop, and to my mind it is degrading to men who are undoubtedly of high intellect and ability."

YOUR BLUE SHIELD

Facts About Blue Shield Emergency Service

The provisions of the Blue Shield contract in connection with emergency services differ somewhat from the provision for services which do not come under the classification of emergency care.

1. Non-emergency care is provided only when rendered by participating physicians, whereas emergency care is provided for services by any licensed doctor of medicine, whether in the State of Florida, or in any other state.

2. The amounts listed in the Schedule of Benefits for the services provided are the same for emergency or non-emergency care.

3. Certain additional benefits are provided for emergency care, an example of which is outpatient

x-ray rendered within 24 hours of an accident for suspected fractures or dislocations. No other x-ray service is provided unless the patient is hospitalized. Outpatient x-ray service is provided in the hospital emergency room, the doctor's office or the home.

4. Surgical treatment for lacerations, fractures, dislocation, etc., is provided in accordance with the Schedule of Benefits. Care for lacerations, burns and other care of that nature comes under the classification of "Individual Consideration" and all such cases are reviewed individually on their own merits. For that reason it is suggested that in submitting these reports, detailed descriptions of the surgery done will facilitate prompt payment. Such reports are reviewed by a Claims Committee, made up of several doctors of medicine who frequently review cases of this nature. These doctors are representatives of several specialty groups who review cases in conjunction with the Medical Advisor of the Blue Shield Plan.

5. The only exclusions for minor surgery rendered non-hospitalized patients are anesthesia, pathology, obstetrical care and x-ray not in connection with acute fractures and dislocations.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

Homer L. Pearson, Jr., Miami, Allapattah Exchange Club
Cleland D. Cochrane, Daytona Beach, Palmetto Clubhouse
Christian Keedy, Miami, Business and Professional Girls' Club

Herman Boughton, Miami Beach, North Miami Lion's Club

Richard F. Sinnott, Ft. Pierce, Ft. Pierce Board of Realtors

Russell B. Carson, Ft. Lauderdale, Hollywood Rotary Club
Jere W. Annis, Lakeland, local Rotary Club



RADIOLOGIST SEEKS ASSOCIATION: With Hospital, Group, or other Radiologist. Board Diplomate, Diagnosis and Therapy. Age 35. American, Cornell Graduate, healthy, hard worker. Florida license. Write 69-33, P. O. Box 1018, Jacksonville, Fla.

DEATHS

Deaths — Members

Hardenbergh, John A., St. Petersburg	March 1, 1950
Hendricks, Elliott M., Ft. Lauderdale	Feb. 28, 1950
Hall, John E., Miami	March 11, 1950
Chalker, James L., Ocala	March 13, 1950

Deaths — Other Doctors

Roper, Luther E., Hollywood	March 15, 1950
Adams, Dallas H., Milton	March 15, 1950
Murphy, Hugh K., Mulberry	March 1, 1950
Moore, Alfred, Memphis, Tenn.	Jan. 6, 1950
Goehring, Harrison D., Montclair, N. J.	Jan. 17, 1950

NEW MEMBERS

Boese, Herman L., Ft. Lauderdale
Brammer, Fred E., Dania
Childers, Stanley G., Cantonment
Cronkite, Alfred E., Ft. Lauderdale
DiCosola, Michael A., Sarasota
Droege, Frederick D., Sarasota
Ellis, Robert S., Pensacola
Farnell, Crowley M., Live Oak
Gilbert, N. Stuart, Miami Beach
Haynal, Andrew P., Orlando
Holmes, James W., Miami
Jesacher, Andrew J., Sarasota
Klenk, Leo F., Pensacola
Liddy, Eugene D., Jr., Sarasota
McCrory, Charles F., Jacksonville
McCurdy, Gordon J., Miami
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Shannon, William A., Sarasota
Sloane, Jack A., Miami
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Tomlinson, Walter B., Warrington
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White, Donald P., Jr., Jacksonville
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FOR SALE: Physician's office equipment. Instruments, Instrument Cabinets, Examination Table and other items. Contact doctor's widow, Mrs. James L. Chalker, 806 Ocklawaha Avenue, Ocala, Fla. Telephone 449.

STATE NEWS ITEMS

Dr. John C. Ajac, Coral Gables, has just returned from a two-year residency in radiology and is now associated with Dr. Gerard Raap.

Dr. Russell L. Counts of Branford has been appointed to a position on the staff of the world-famous Lahey Clinic of Boston. Dr. Counts is one of twelve doctors in the entire United States to be selected for a year's fellowship in the practice of advanced surgery at this clinic.

Dr. Frederick K. Herpel, West Palm Beach, recently addressed the local Lion's Club on the subject of cancer. Dr. Herpel urged periodic physical examinations and immediate investigation of any suspicious symptoms.

Dr. Carolyn Williams, Orlando, spoke on the subject of safety before a recent meeting of the local Business and Professional Women's group.

Dr. William T. Futch, St. Petersburg, is leaving Florida to become a fellow in internal medicine at the Mayo Clinic for the next two years. Dr. Futch will specialize in cardiology and plans to return to St. Petersburg on the completion of his study.

Dr. Donald W. Smith, president of the Dade County Medical Association, has announced that a grievance committee on a county level is now functioning. Dr. Smith has called the new unit "an important step forward for the medical profession in its efforts to bring about better understanding between doctors and the public."

Dr. Nathan Weil, Jr., Jacksonville, recently spoke on health and prevention of children's diseases at a meeting of the Parents' Club of St. Elizabeth's Academy.

Dr. Lorenzo L. Parks, acting director of the Florida State Board of Health Bureau of Preventable Disease, with headquarters at Jacksonville, was one of the featured speakers recently at a cancer seminar at Salt Lake City. The cancer seminar was sponsored by the University of Utah. Dr. Parks spoke on progress being made by Florida's cancer control program, which has been un-

der way for nearly three years. The seminar was held there March 2-4.

Florida doctors who attended the Southeastern Surgical Congress at its meeting in Washington, D. C., March 6-9 include: Drs. Peter A. Droghamer and Alphonsus M. McCarthy, Daytona Beach; Howard G. Holland, Leesburg; Joseph S. Stewart, Miami; Carl D. Hoffman and Louis M. Orr, II, Orlando; Julius C. Davis, Quincy; Francis H. Langley, St. Petersburg; A. Lamar Matthews, Jr., Sarasota; and John S. Helms, Jr. and Wade C. Myers, Jr., Tampa.

The Committee on Medical Motion Pictures of the American Medical Association has completed the second revised edition of the booklet entitled "Reviews of Medical Motion Pictures," containing 225 reviews of medical and health films. Copies are available at a cost of 25 cents each from: Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The 34th Tournament of the American Medical Golfing Association will be held at the Olympic Golf Club, San Francisco, Monday, June 26, on the opening day of the 1950 A.M.A. Annual Session.

Fellows planning to participate should send, as soon as possible, their name, handicap, and section in medicine in which they will register to Secretary Wm. J. Burns, 2020 Olds Tower, Lansing 8, Michigan.

The detailed program of the AMGA Tournament will appear in the Convention Number of the AMA Journal.

Applications for membership may be obtained by writing to Secretary Burns, 2020 Olds Tower, Lansing 8, Michigan.

County Medical Society officers will meet in San Francisco, June 25, for the Seventh National Conference of County Medical Society Officers. All physicians are invited but county society officers are especially urged to attend. This meeting, known as the Grass Roots Conference, is under the sponsorship of the A.M.A. Board of Trustees. Florida's representative is Dr. Whitman C. McConnell, St. Petersburg.

COMPONENT SOCIETY NOTES

Alachua

Dr. Francis E. Ray, director of Cancer Research at the University of Florida, was the guest speaker at the March meeting of the Alachua County Medical Society. Following the meeting, Dr. Ray conducted the members through the Cancer Research Laboratory of the University.

Dr. Alva T. Cobb, Jr., Gainesville, was elected a trustee of the society at the same meeting.

Brevard

Members of the Brevard County Medical Society recently were guests of the medical staff of the Florida Rapid Treatment Center, Melbourne. Guest speaker for the evening was Dr. J. J. Clark, Atlanta roentgenologist, who presented lantern slide demonstrations on x-ray diagnosis.

State dues for 1950 have been paid by all members of this society.

Broward

The Broward County Medical Society held its annual public meeting at the Southside Auditorium in Ft. Lauderdale. The main topic of discussion was "The Status of the Medical Situation in Broward County." Dr. Richard A. Mills, president, was in charge of the meeting and introduced the chief speaker, Mr. Robert G. Carter, Tallahassee, director of the hospital division of the Florida State Planning Commission. Mr. Carter outlined the financial help available from the state and federal governments with regard to hospitals. Among the groups represented were officials from the county and city governments, neighboring community civic clubs, dental, nursing and pharmaceutical professions, apartment and hotel associations, ministerial, Woman's and veterans' groups and health and welfare agencies.

Dade

Dr. James H. Mendel, Miami, speaking to his fellow members at the March meeting of the Dade County Medical Association, urged conservatism in the treatment of acute sinusitis. Dr. Mendel's paper was discussed by Dr. Nathaniel M. Levin.

The April issue of the Bulletin of the Dade County Medical Association pays special tribute to two outstanding men of medicine, Dr. Homer L. Pearson, one of the Florida delegates to the A.M.A., and Dr. Carlos P. Lamar, associate editor of The Journal.



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Marion

At the March meeting of the Marion County Medical Society, Dr. Eugene G. Peek, Jr., presented to his fellow members a warning as to the danger of possible poisoning to handlers in mixing and using a new product for spraying citrus trees. Dr. Peek urged that persons engaged in this occupation be cautioned to wear rubber gloves, face masks and other body protection.

The following members were present: Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, Bertrand F. Drake, Henry L. Harrell, John D. Lindner, Carl S. Lytle, John N. Moore, John P. Moore, Eugene G. Peek, Jr., Ralph E. Russell, Robert E. Thompson, Thomas H. Wallis and Jack M. Waldrep, Ocala, and John J. Cheledin, Ocklawaha. Guests were members of the Florida legislature and candidates for state representatives: Hon. Wallace E. Sturgis, Hon. Marcus Frank and Mr. Willard Ayres, Ocala, and Mr. L. K. Edwards, Irving.

All members of this society have paid their 1950 dues.

Pinellas

The regular monthly meeting of the Pinellas County Medical Society was held at the Detroit Hotel with the president, Dr. Alfred R. Frederick, presiding. Dr. B. T. Bell presented a paper, illustrated with colored slides, "Diseases of the External Eye."

The Society recently sponsored the appearance of Ralph J. Gampell, eminent British physician, at the St. Petersburg and Clearwater Rotary Clubs. Dr. Gampell discussed the operation of the British National Health Program. Later Dr. Gampell appeared on a radio program over station WSUN St. Petersburg.

Concurrently with the talks made by the British physician, several speakers from the society discussed compulsory health insurance before numerous lay groups. According to the News Letter of the Pinellas Committee on Public Education, approximately 1200 people were contacted through these speakers.

Pasco-Hernando-Citrus

The Pasco-Hernando-Citrus County Medical Society held its February meeting at the home of Dr. George R. Creekmore, Brooksville. Guest speaker of the evening was Dr. Mason Trupp, Tampa, who discussed head injuries and their

(Continued on page 710)



From where I sit by Joe Marsh

Handy and Easy Are Both Wrong

Handy Peterson and Easy Roberts got in an argument the other day over at Fred's Garage talking about the best spot to fish up at Green Lake.

"Opposite the old sawmill is the best spot," says Handy. But Easy "pooh-pooh's" him. "I've seen the biggest fish caught off Cedar Point," says Easy. "I've been catching them there for years."

Then Fred goes into his office and brings out the biggest mounted trout you ever saw. "Bet that was caught at the sawmill," comments Handy. "Cedar Point," says Easy. "Well," says Fred, "you're both wrong. I caught this right out in the middle!"

From where I sit, there are always two (or more) sides to every story. Let's live and let live in the true American tradition of toleration. Your opinion is worth a lot, but so is the other fellow's—whether it's on politics, the best fishing spots, or whether he likes a temperate glass of beer and you like buttermilk.

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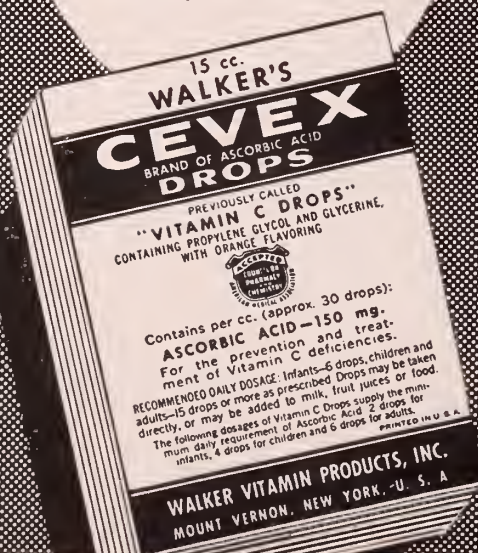
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treatment. Members present were: Drs. Frank J. Farley and W. Wardlaw Jones, Dade City; George R. Creekmore and S. Carnes Harvard, Brooksville; Jere W. Kirkpatrick and Gail M. Osterhout, Inverness. Attending also was Dr. William H. Garvin of Dunnellon.

Sarasota

The Sarasota County Medical Society sponsored a medical seminar in Sarasota February 27-March 2. The program was composed of five nights of lectures by the following professors of the Duke University School of Medicine: Drs. William Nicholson, Associate Professor of Medicine; Guy Odom, Associate Professor of Neurosurgery; Angus McBryde, Associate Professor of Pediatrics; Bayard Carter, Professor of Obstetrics and Gynecology. The subject matter of the lectures was chosen so as to be of value to the general practitioner as well as the specialist. The seminar was attended by doctors from many sections of the west coast as well as from Sarasota.

The Sarasota County Medical Society has paid 100% state dues for 1950.

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GYNECOLOGY—Intensive Course, Two Weeks, starting June 19, September 25. Vaginal Approach to Pelvic Surgery, One Week, starting May 15.

OBSTETRICS—Intensive Course, Two Weeks, starting June 5, September 11.

PEDIATRICS—Personal Course in Cerebral Palsy, Two Weeks, starting July 31. Personal Course in Diagnosis & Treatment of Congenital Malformations of the Heart, Two Weeks, starting June 5.

MEDICINE—Intensive General Course, Two Weeks, starting October 2. Electrocardiography & Heart Disease, Two Weeks, starting July 17. Hematology, One Week, starting May 8. Gastro-enterology, Two Weeks, starting May 15. Liver & Biliary Diseases, One Week, starting June 5. Gastroscopy, Two Weeks, starting May 15, June 12.

DERMATOLOGY—Formal Course, Two Weeks, starting May 8. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 25. Cystoscopy, Ten Day Practical Course, every two weeks.

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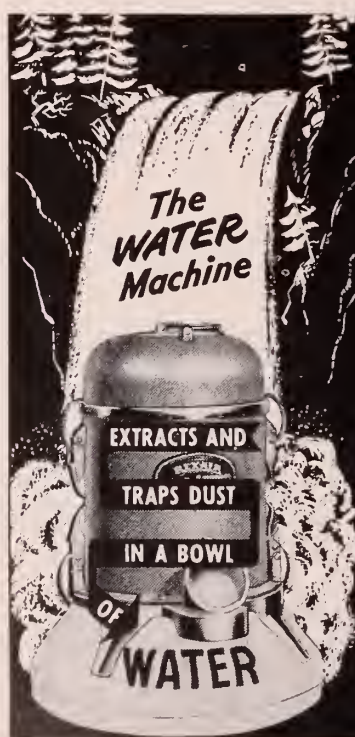
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1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1945.

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Walter C. Payne, Pensacola	Robert B. McIver, Jacksonville	Hollywood, Apr. 23-26, 1950
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Marianna
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochran, Daytona Beach	Ocala
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Ft. Myers
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	West Palm Beach
Florida Specialty Societies			
Allergy Society	Frank C. Metzger, Tampa	G. F. Hieber, St. Petersburg	Hollywood, Apr. 23, '50
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	Walter E. Murphree, Gainesville	John A. Wilhelm, Jacksonville	" "
Chapter, Am. Coll. Chest Phys.	Earlsworth C. Brunner, Miami	Howard K. Edwards, Miami	" "
Derm. and Syph., Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	Frank L. Quillman, Sanford	Lorenzo L. Parks, Jacksonville	" "
Heart Association	E. Sterling Nichol, Miami	Jere W. Annis, Lakeland	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	W. C. McConnell, St. Petersburg	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert G. Nelson, Tampa	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	W. Jerome Knauer, Jacksonville	Charles C. Grace, St. Augustine	" "
Orthopedic Society	Eugene L. Jewett, Orlando	Plumer J. Manson, Miami	" "
Pathological Society	Gretchen V. Squires, Pensacola	Nelson A. Murray, Jacksonville	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	John A. Beals, Jacksonville	John J. McGuire, Pensacola	" "
Urological Society	A. Fred Turner, Jr., Orlando	Linus W. Hewit, Tampa	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.A.M., Gainesville	Gainesville, June 3, '50
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. F. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	November, 1950
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, June 25-27, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 26, '50
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 23, '50
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	Daytona Beach, May 23-25, '50
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	
Woman's Auxiliary	Mrs. Charles F. Henley, Jacksonville	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 24-26, '50
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	C. P. Loranz, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	Frank C. Wilson, Birmingham	Douglas L. Carnon, Montgomery	
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	
S. E. Hospital Conference	Mr. James M. Crews, Memphis	Mr. I. H. Gunter, Montgomery	
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacDonis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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				Total	Paid	
Bay	Daniel M. Adams, Jr., M.D. Box 593 Panama City	Jack Corbitt, M.D. Box 961 Panama City		17	16	A-1-50 William P. Hixon, M.D. Pensacola
Escambia *Santa Rosa	Jesse N. McLane, M.D. 1212 N. Palafox St. Pensacola	Arthur J. Butt, Jr., M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	71	66	
Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
Jackson *Calhoun	James T. Cook, M.D. Box 110 Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	3rd Thursday 7:30 P.M.	18	16	
Walton-Okaloosa	Allen A. Enzor, M.D. Crestview	Arthur G. Williams, Jr., M.D. Valparaiso	3rd Thursday 8:00 P.M.	15	100%	
Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
Columbia *Baker-Hamilton	Robert B. Harkness, M.D. 525 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	A-2-51 Taylor W. Griffin, M.D. Quincy
Leon-Gadsden- Liberty-Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	47	43	
Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		7	100%	
Madison	Eugene D. Thorpe, M.D. Madison	935 Arlington St. Madison		4	3	
Taylor *Davis-Lafayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	

210

B

Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 331 W. University Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	44	43	B-3-50 Charles C. Grace, M.D. St. Augustine
Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	244	221	
Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Wednesday 12:30 P.M.	28	100%	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	100%	
St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	14	13	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	17	100%	
Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	21	100%	
Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	134	116	
Seminole	Charles L. Park, M.D. 109 W. 17th St. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Eric H. Lenholt, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	59	49	

592

C

Hillsborough	David R. Murphey, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	154	143	C-5-51 M. Crego Smith, M.D. Clearwater
Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	18	
Pasco-Hernando- Citrus	S. Carnes Harvard, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	10	
Pinellas	Albert R. Frederick, M.D. 408 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	167	164	
Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	33	100%	C-6-50 H. Quillian Jones, M.D. Ft. Myers
DeSoto-Hardee- Highlands- Charlotte-Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	28	24	
Lee *Collier, Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	24	23	
Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	85	73	

524

D

Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-50 Erasmus B. Hardee, M.D. Vero Beach
Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	96	92	
St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	14	
Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	73	66	D-8-51 S. Marion Salley, M.D. Miami
Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	534	398	
Monroe	Herman K. Moore, M.D. 600 Elizabeth St.	Wallace H. Mitchell, M.D. 217 Duval St.	2nd Thursday 8:00 P.M.			



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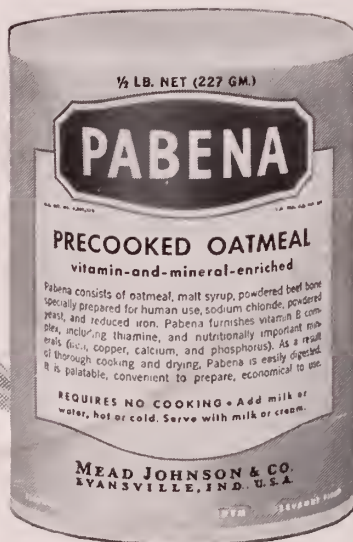
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI

JUNE, 1950

No. 12

IN THIS ISSUE

Proceedings Hollywood Convention

House of Delegates Actions
Scientific Assemblies
General Sessions

President's Address

Walter C. Payne

Index to Volume XXXVI

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Volume XXXVI

JUNE, 1950

No. 12

CONTENTS

CONVENTION EVENTS

President's Address, Walter C. Payne, M.D.	739
Proceedings of Seventy-Sixth Annual Meeting:	
First General Session	744
Second General Session	744
Third General Session	750
First House of Delegates	750
Second House of Delegates	752
Scientific Assemblies	771
Registration at Annual Meeting	772

EDITORIALS

Seventy-Sixth Annual Meeting A Great Success	777
Progress at the Annual Meeting	777
Television in Medical Education	778
Better Public Relations	778
Labeling Requirements for Prescriptions	778

COMMENTARIES

Medical Golf Tournament	778
Pan American Ophthalmology-Antiblindness Meeting	779
Eighteenth Annual Graduate Short Course	779

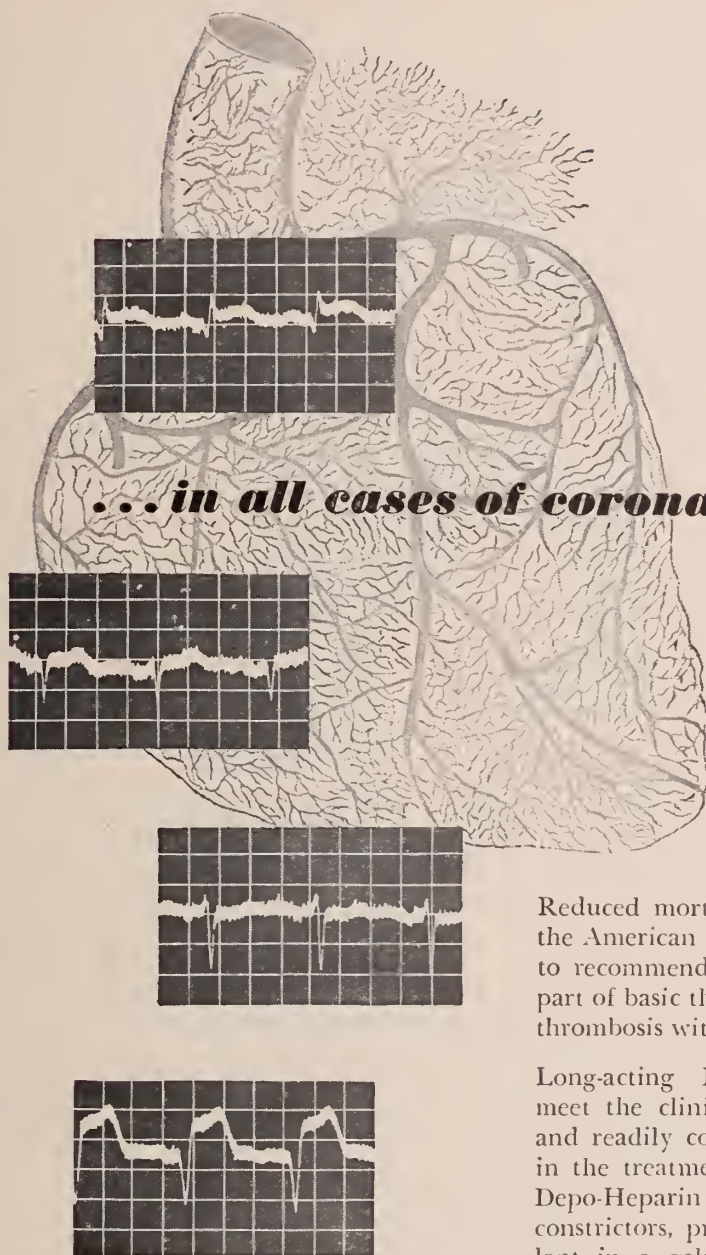
GENERAL FEATURES

Officers and Committees	774
Herbert E. White, M.D., the New President	776
Schedule of the Short Course	780
State News Items	781
New Members	782
Births and Deaths	782
National Education Campaign	782
Component Society Notes	782
Your Blue Shield	783
Obituaries	784
Woman's Auxiliary:	
President's Report	786
Dr. White's Address	787
Books Received	803
Schedule of Meetings	805
List of County Medical Societies, Presidents, and Secretaries	806

INDEX TO VOLUME XXXVI

788

This Journal is not responsible for the opinions and statements of its contributors.



...in all cases of coronary thrombosis

Reduced mortality and morbidity have led the American Heart Association study group to recommend the use of anticoagulants as part of basic therapy "in all cases of coronary thrombosis with myocardial infarction."¹

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1. Wright, et al: *Am. Heart J.* 36,801 (Dec.)1948.

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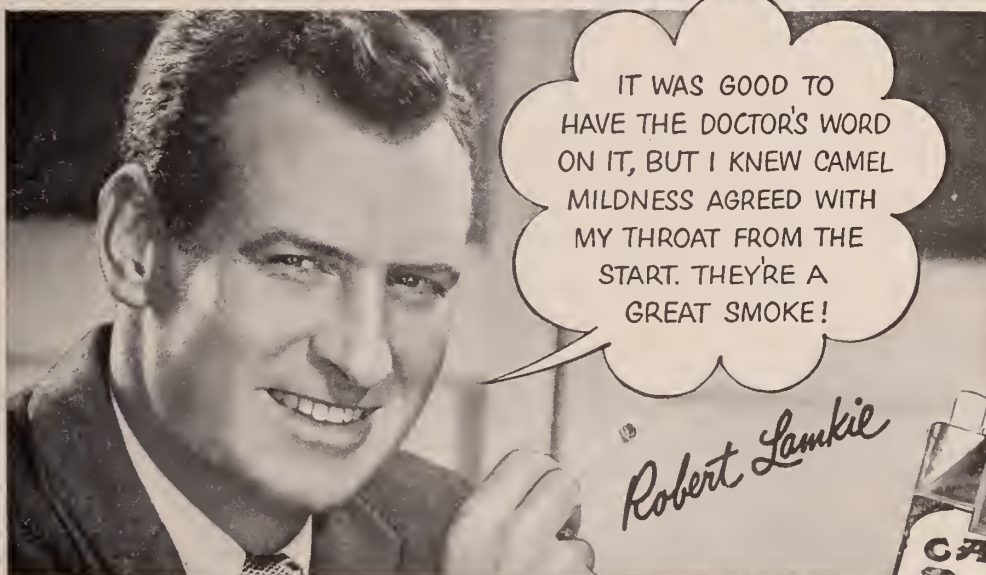
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Personnel Director

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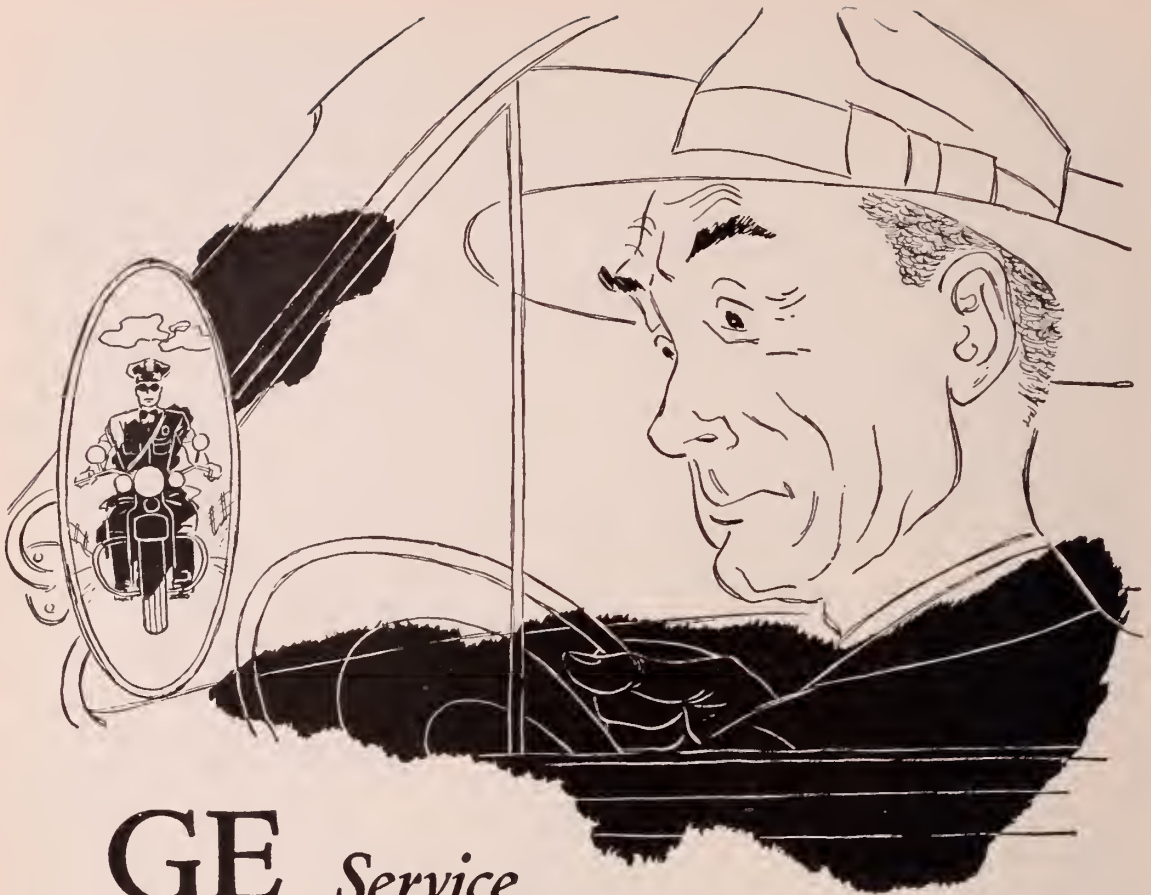
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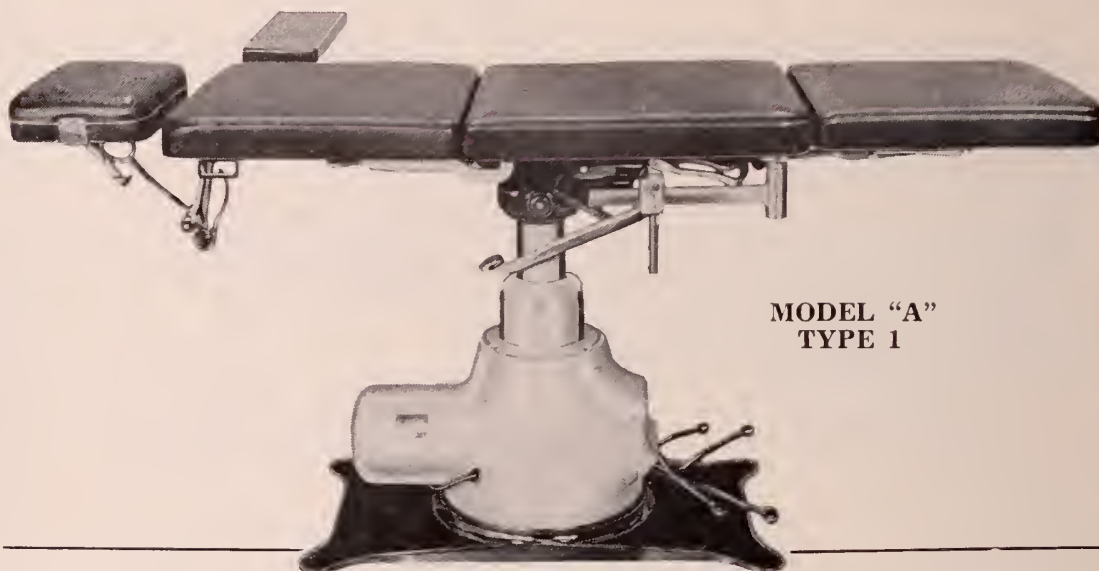
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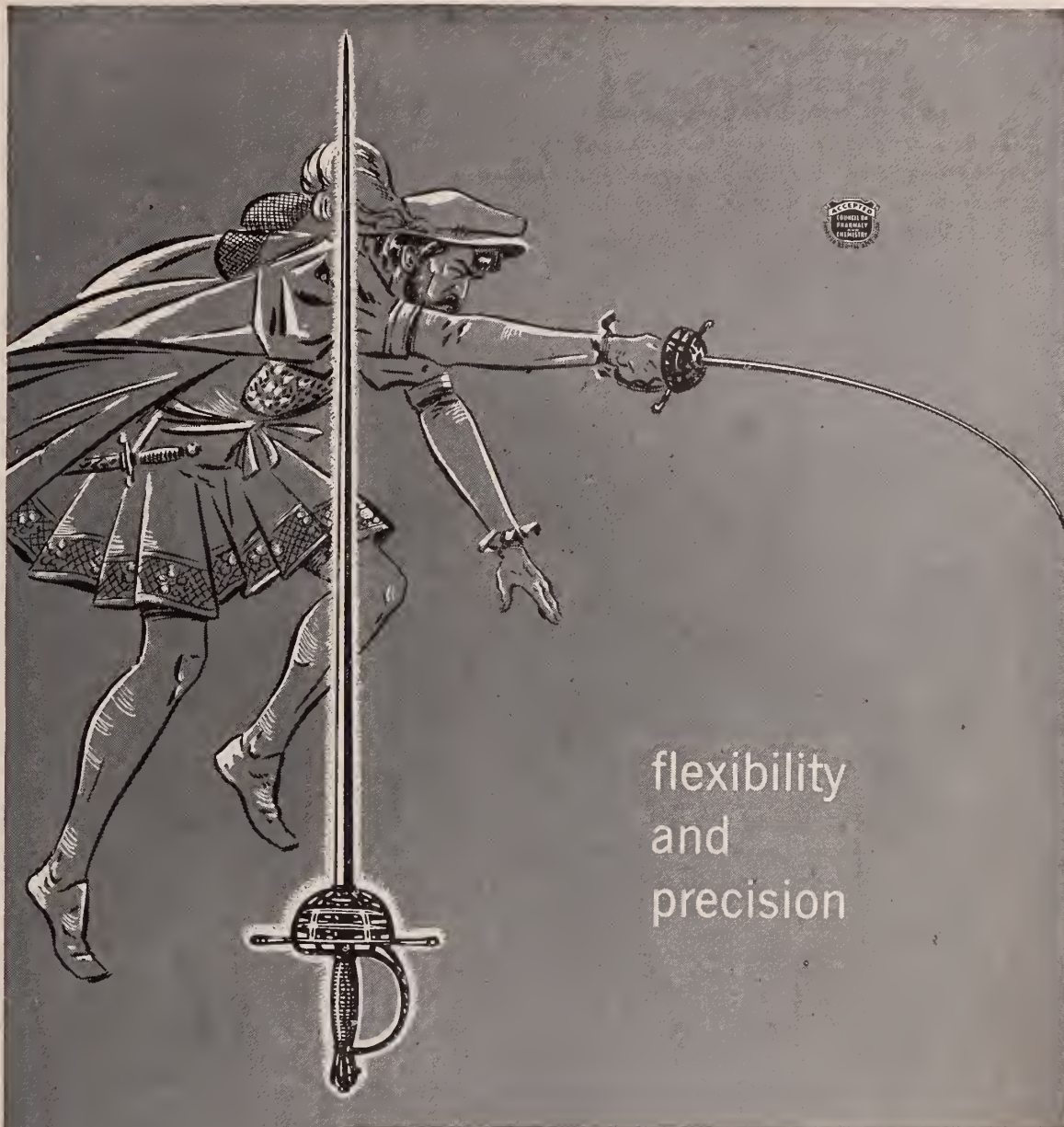


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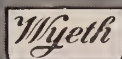


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Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.

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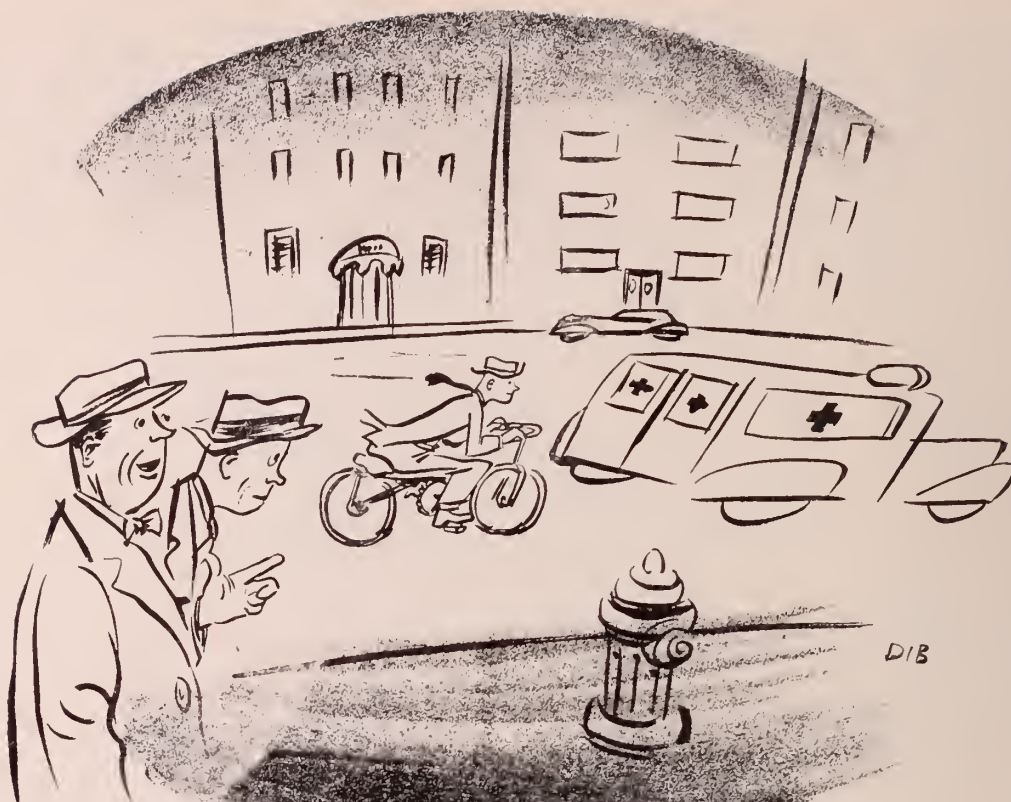
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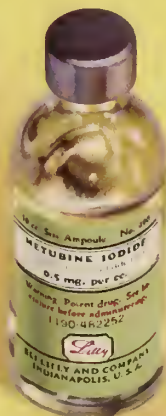
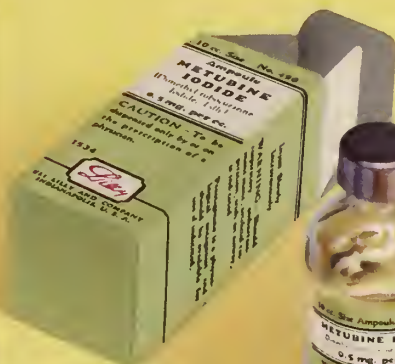
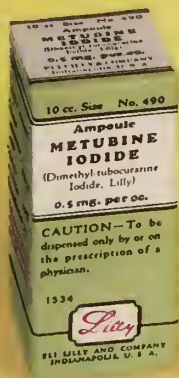
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“within the borders of Macoushia

... a different tribe of people, uncommonly dexterous in the use of the blowpipe, are famous for their skill in preparing the deadly vegetable poison called Wourali.” From the time of early South American explorations until now, observations on the properties of curare have caused it to be brought from the jungle to research lab-

oratories. There it has recently been developed into a useful adjunct to anesthesia. It induces relaxation of skeletal muscles, permits smaller dosage of anesthetic agents, facilitates surgery.

The Lilly Laboratories have improved on the effectiveness of earlier curare compounds. ‘Metubine Iodide’ (Dimethyl-tubocurarine Iodide, Lilly) possesses a greater margin of safety.

Lilly

ELI LILLY AND COMPANY
INDIANAPOLIS 6
INDIANA, U.S.A.

President's Address

WALTER C. PAYNE, M.D.

PENSACOLA

To hold the highest office in the Florida Medical Association is an honor to be coveted, a privilege to be enjoyed and a stimulating experience fraught with memories long to be cherished. For the opportunity of serving you in this capacity I am deeply grateful. In the exercise of the office of president, I have found the excellent cooperation of the membership to be the most gratifying aspect of the work. It is this cooperation which has made possible the year's accomplishments.

The other administrative officers and the Board of Governors are to be commended most heartily for their able assistance in promoting the interests of the Association. They have traveled far, have attended meetings most faithfully and have given freely of their time, experience and judgment. The members of the various committees are likewise to be highly commended for the excellent manner in which they have discharged their duties under the competent leadership of their respective chairmen. Some committees have of necessity given more time and effort than others to their particular tasks because of the nature of their assignments, but all have labored diligently as the need required. They have earned my sincere appreciation and yours, and on behalf of the entire membership I thank them.

The Association is to be congratulated on its good fortune in having had for more than two decades Dr. Stewart G. Thompson as its managing director. His wisdom, patience, efficiency and unflagging zeal have been a bulwark in time of trouble and a never ending source of satisfaction across the years. To him I am greatly indebted for his courteous consideration and constructive assistance throughout my term of office.

This is the fourteenth year that the district meetings have proved their worth as an important step in the progress of the Association. Until one

attends officially all of these meetings in close succession, as was my privilege last October and the two years before as chairman of the Board of Governors and as president-elect respectively, he does not realize fully their great value. They promote between the officers and members informal discussion of their common problems; they stimulate interest through scientific programs; and they advance the welfare of the Association through broadened fellowship.

The Changing Times

At this seventy-sixth session of our state society we hardly need reminding that during the last quarter of a century we have witnessed a radical change in medical economics and in our public relations. The older ones of us remember, with a feeling of nostalgia, the time when the motives, integrity and sincerity of purpose of the medical profession were never questioned. The doctor occupied a place in the public esteem second to none.

The time has arrived for us to analyze the situation without bias. We must find out why a part of the public has become dissatisfied and then do whatever is necessary to remove the cause or causes of this dissatisfaction. The public can be divided into two groups: the distributors of medical care and the consumers of medical care. We as distributors must never overlook the fact that the consumers are as vitally interested in health problems as we are.

Voluntary Versus Compulsory Health Insurance

We realize fully that through no fault of ours the cost of medical and hospital care has become a burden on people of moderate income. No one knows better than the physician what a catastrophe it is when a family in this income bracket is suddenly confronted with the necessity of a major surgical procedure. There is nothing that we can do to lower the cost of medical and hospital serv-

ice, but we do have a definite positive plan so to distribute this cost that it can be met without undue financial hardship on anyone.

I think we all, including the politicians, agree that prepayment health and hospital insurance is the answer. Where we violently disagree is on the method of financing this insurance. We believe that it should be done on a voluntary basis; its political proponents believe that it should be compulsory. Necessarily, compulsory health insurance would mean governmental control of the practice of medicine.

All who keep abreast of the press and radio statements of the Federal Security Administrator, especially since his recent tour of investigation in England, must realize how imminent is the threat of governmental medicine. Surely no one can question that we moved appreciably nearer state medicine with the 1948 elections. Which way we shall move, particularly in Florida, in the coming election is of vital import not alone to ourselves and our profession but to every citizen in the nation; and indeed the direction we shall take at this crucial time will have international repercussions.

There is much more than medicine's cause at stake in this year's congressional races. The dominant overshadowing issue is whether the American people are ready to abandon ship and to exchange their independence for state socialism. Socialized medicine has become the blazing focal point in this controversy. If the nation's doctors need a great challenge to rally American medicine to a supreme effort, we have it. It is important, critically important, that we doctors do everything within our power this year to stop the march of socialism in this country, stop it at the polls by aiding in the election of members of the Congress who will have the courage to stand out against compromise and who will crusade for American principles.

The people of America this year, more than any other time in history, will be turning an appraising eye on our profession and the program of medical care which we sponsor. The work of our voluntary health insurance system will be weighed in the balance against the extravagant claims and promises of the proponents of a compulsory system.

Failure to Inform the Public

Since the beginning of medical history, the followers of Aesculapius have avoided publicity.

In so doing we have allowed the public to receive its medical information from persons with selfish interests, quacks and members of off brand cults who advertise freely. We have failed to realize that the public, being vitally interested in medical matters, has a right to be properly informed. And who is better qualified, by reason of training and experience, to give this information than the men and women who have spent their lives rendering medical service? I do not believe we can escape the fact that it is our duty and our responsibility to supply this information.

Our Public Relations

In bygone years the medical profession did little in giving publicity to its problems. But times have changed, and it is hard to believe that our ethics should not be adjusted accordingly. The modern physician faces problems which must be understood by the lay public if these problems are to be solved. Regimented medicine, state medicine, socialized medicine, or call it what you will, is truly an imminent threat. It is making its advances in the open as well as in the darker byways. Its advocates use every means of propaganda and publicity possible. If the medical profession is to combat this, it must use similar weapons.

If an active campaign is to be waged against regimentation, the old medical attitudes regarding publicity and public relations must be changed. If our profession confidently believes that it should resist all efforts of governmental control, then it must sell to the public the conviction that it has more to offer than could be offered under a federal or state program. We, in the medical field, conclude that forthright intelligent attempts to inform the public are desirable.

The Florida Medical Association, along with the American Medical Association and with other state associations, uses the radio, motion pictures, exhibits, speeches, posters, pamphlets, magazines and word of mouth, as well as newspapers, to tell about medical advances and the medical profession.

Remember that there is no group in existence with a greater potential force for excellent public relations than our profession. Patients, friends and acquaintances all look to their doctor of medicine not only for health care but also for family guidance. They call on him both to set a broken arm and to sympathize with a broken heart. Because of his or her high standing, an

individual doctor can unwittingly harm the entire medical profession by some example of poor public relations.

We doctors must feel a keen responsibility in keeping medicine a free science, unchained and untrammled. We must do everything possible to keep American Medicine what it is today, the best in the world. Every doctor must make a special point to tell and to keep on telling the people more and more about the work of our profession, its trials, its successes, and even its failures. There is no magic formula for accomplishing all this. The only way I know to reach our goal is to widen our horizon and join our forces, thus weaving a nationwide blanket of public good will which will protect us against the coldest ill wind that blows.

To help us perform this service, our Association has a Bureau of Public Relations, whose supervisor is Mr. William Harold Parham. It is the function of this bureau, through the press, the radio and the speaking forum, to inform the public on medical matters. It is also its function to tell our story. Until recently there has been no one to look after our interests and to get our story before the public in a favorable light. This bureau operates in close cooperation with the Committee on Public Relations of our Association and with the county societies as they carry on this important work.

In informing the public of our problems through this excellent medium, we may well emphasize that we, not the politicians, are the ones who can best do the job. It is our mission to convince the public, and I am sure we can, that under state medicine service would inevitably be far inferior to that being rendered now under the practice of medicine as a free enterprise. We should go about this task in a dignified manner. Your Board of Governors has, in fact, gone on record as requesting that our arguments against governmental control of medicine be kept on a high plane. We should of course avoid personalities and name-calling and should confine our arguments to the issues involved. There is no need to becloud these issues with irrelevant matters for there are plenty of good, sound, logical facts with which to win our argument. There is likewise no point to blaming the public too much. Let us look to ourselves, conduct ourselves properly and inform the public wisely; then we shall win confidence and ultimately the battle for freedom.

State Grievance Committee

In the course of promoting better public relations between the medical profession and the public, there has recently come to be recognized the need for a medium through which patients may voice their grievances, real or fancied, against the profession. To meet this need, several state medical associations have established a committee on a state level to which such complaints may be presented. Such a committee is functioning successfully in at least eight state associations (Colorado, Indiana, Nebraska, New Mexico, Oklahoma, Utah, Virginia and West Virginia), and other state societies are adopting this plan. At its 1949 midwinter session, the House of Delegates of the American Medical Association approved a resolution commending those constituent associations which have already established such a committee and urging the remaining ones to adopt a comparable program.

I therefore recommend that this Association by action of its House of Delegates authorize the establishment of a grievance committee to hear and weigh complaints from the public relative to the profession and medical practices, and that this committee be composed of the five immediate past living presidents. I further recommend that this committee be empowered immediately to make such surveys of the experiences of other state medical associations as it deems essential and to draft rules and regulations to govern its activities, that the necessary funds for operating expenses be subject to the approval of the Board of Governors and that an annual report be made to the House of Delegates.

County Mediation Board

As a second specific recommendation, I propose that each constituent county medical society be urged to establish a mediation board, or similar committee by whatever name, which will serve as a screening committee for ironing out misunderstandings and differences between patients and physicians and settling them amicably and as quickly as possible. In many instances, such complaints need not then be referred to the grievance committee at the state level. Certainly it is to the interest of the profession and the public alike that differences be settled promptly and locally if possible, and it would seem that the county medical society is the logical unit to resolve such problems with diplomacy and dispatch. The pattern of the mediation board at

the county level should as nearly as practicable follow that of the grievance committee at the state level. By this means public relations should be steadily improved locally, and the work of the state committee should be greatly expedited, provided this board is widely publicized and adequately kept before the laity at all times.

President's Recommendations

Too often through the years the recommendations of successive presidents have borne no fruit because they have been allowed to become buried in cold print in the president's address with no action taken upon them. Accordingly, I am introducing an innovation at this time which I trust will in future become routine procedure. I am, as a delegate, presenting my recommendations for a grievance committee at the state level and a mediation board at the county level to the House of Delegates in the form of resolutions for action by that body. I suggest that this practice be followed in future so that the Association may by formal action benefit as it sees fit by the proposals which are the fruits of the experience of its presidents during tenure of office.

Office Personnel

In view of the vital importance of public relations today, it seems not inappropriate to make certain observations that may be helpful reminders. We are inclined to pay too little attention to our office personnel, forgetting how strategically situated our assistants are to be ambassadors of good or ill will in their contacts with the laity. It is highly important that we choose the members of our office staffs with extreme care, keeping the public relations aspect well in mind. Then we must take the pains to educate them in the problems of our profession, instructing them particularly in the human interest values involved. Every doctor should teach his receptionist to be courteous and efficient, to think quickly, and to demonstrate a personal interest in every patient, particularly on the telephone.

With this training put into practice, these young women are in a position to make friends for the profession and to counteract the all too frequent and the all too often justified complaint of patients that they receive disinterested treatment, inefficiency and even downright rudeness at the hands of the doctors' assistants. Many a physician might find it a revealing experience to check up on his office by telephoning for an appointment. In too many instances the public attitude

would become more understandable and excusable.

The medical service men, the pharmaceutical representatives who call upon the doctors regularly, are another public relations asset. They spend much time in our offices, where they contact both the laity and the office personnel. We have the opportunity to make of them excellent liaison agents; but we must treat them courteously, show them due consideration in the office and at the exhibits, and make the effort to cultivate their friendship. In the states, Oklahoma in particular, where the medical profession has encouraged and assisted the organization of this group, the society formed has been most helpful in furthering wholesome public relations.

Code of Ethics

Every member of the Association recently received a booklet entitled "Principles of Medical Ethics of the American Medical Association." How many of you have read it? For generations too many of us have been content to practice on what we have heard was our code of ethics, and far too few have taken the time and trouble to read and actually study this code. All of us would do well to review, for example, Chapter III, Article III, entitled "Duties of Physicians in Consultations." The laity is not versed in how properly to obtain a consultation, and too often neither is the physician. When the ethical aspects of this feature of medical practice are properly understood and are adhered to with suitable decorum, relations within the profession and with the laity are always improved.

"The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals." So reads the opening statement of the code, and the concluding statement follows: "These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles."

I earnestly suggest that every county medical society devote one program this year to the code of ethics, important as it is to public as well as professional relations. In my opinion, no man or

woman has the right to practice medicine who will not take the time to read and study and then follow this code. It cannot be stated too emphatically that if ever there was a time when we of the medical profession need to conduct ourselves in a manner that will deserve and receive from the public good will, confidence and faith, it is now.

Conclusion

The American Medical Association is 103 years old. For more than 75 years after its organization it interested itself almost exclusively in the preservation and prolongation of life and health. It goes without saying that we must continue our scientific advancement, never forgetting that it is the one road that leads to medicine's goal of better health and longer life for our people. In our enthusiasm for scientific improvement we must not, however, neglect the art of practice. Let us never forget that medicine must be practiced with the heart as well as with the head. Too, we must teach the men and women coming into our profession to appreciate their rich heritage.

I should like to close by telling you a story about a family all of us know and love. The name of this family is the Practice of Medicine, and its two sons are called Art and Science. Art is much the older of the two boys, and before Science was born, it was a happy and prosperous family. Even after Science was born, it continued to be a devoted family for a long time. It happens, however, that an unfortunate change has occurred—partiality has been shown toward Science. As a result, he is the robust personable son of the family. Even though he is yet a young man, he has already made his mark in the world, and his future looks bright indeed. Art, on the other hand, feels left out of his own family and suffers from an inferiority complex. He is undernourished and anemic; in fact, if something is not done for him, there is a chance that Art may even die. It is your duty and mine to have a heart to heart talk with this family and to persuade it to give Art the same loving and tender care that it is giving Science, to the end that the Practice of Medicine may once again be a united, devoted and happy family.

THE SEVENTY-SEVENTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION

In 1951

Will Be Held at the

HOLLYWOOD BEACH HOTEL

APRIL 22-25, 1951

PROCEEDINGS

Seventy-Sixth Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION
HELD AT HOLLYWOOD
APRIL 24, 25, and 26, 1950

GENERAL SESSIONS

First General Session

The Seventy-Sixth Annual Meeting of the Florida Medical Association was called to order at 9:05 a.m., Monday, April 24, in The Sun Room of the Hollywood Beach Hotel, Hollywood, by President Walter C. Payne.

Invocation was pronounced by The Reverend Edward P. Downey of Ft. Lauderdale.

Dr. Richard A. Mills, president of the Broward County Medical Society gave the address of welcome.

Dr. Payne then introduced Mrs. Richard B. Allman, president of the Woman's Auxiliary of the American Medical Association and Mrs. Charles F. Henley, President of the Woman's Auxiliary of the Florida Medical Association, who spoke briefly.

On request from the Chair for announcements, Dr. Mills reminded the assembly that by referring to their programs, they could find the schedule for trapshooters and golfers.

There being no further business, the meeting adjourned.

Second General Session

The meeting of the Florida Medical Association reconvened at 2:00 p.m., Monday, April 24, in The Sun Room of the Hollywood Beach Hotel; President Payne in the Chair.

The meeting was called to order.

Dr. David R. Murphey, Jr., first vice president, took the Chair and called on Dr. Walter C. Payne to deliver his presidential address.

Dr. Murphey relinquished the Chair and turned the gavel over to President Payne.

Dr. Payne introduced Mr. Lawrence W. Rember, Assistant to the Secretary and General Manager of the American Medical Association, who spoke briefly.

The following report of the secretary-treasurer and managing director was read by Dr. McIver:

Report of Secretary-Treasurer Dr. Robert B. McIver And Managing Director Dr. Stewart G. Thompson

Mr. Chairman, Members of the Association and Guests:

The membership of the Association for the past year exceeded all previous records with a total of 2,032, an increase of 78 over last year's total of 1,954. The following members are not required to pay state dues: life, 81; honorary, 47; in military service, 12; and secretaries of county medical societies, 36, making a total of 176.

The five county medical societies ranking highest in total membership are Dade 529, Duval 247, Pinellas 167, Hillsborough 153 and Orange 134.

Receipts for the fiscal year ending March 20 totaled \$77,021.88 and cash disbursements were \$72,357.80, indicating an apparent gain of \$4,664.08. The following items are shown as income but cannot be expected in the future: Academy of Public Medicine \$2,093.32, miscellaneous \$765.00 and \$2,155.00 more dues collected before books closed in March this year than during the same period last year. The dues are collected on a calendar year basis which makes the fiscal year figures misleading. This total of \$5,013.32 less the apparent gain of \$4,664.08 actually indicates a deficit of \$349.24.

Additional revenue is needed and the Board of Governors, therefore, recommended an increase in annual dues of \$15.00 to cover the cost of additional activities which are not covered in the present current dues of \$25.00.

The Association's office has the responsibility of collecting A.M.A. dues from the county medical societies, keeping an individual record of each member, forwarding remittances to the A.M.A. and mailing carbon copies back to the secretaries. All of the details have to be explained to each of the 36 county medical societies and numerous individual doctors through correspondence which requires stenographic and clerical service plus supervision. This is a much more difficult task than collecting the A.M.A. assessment last year. The estimated cost for this additional load is \$2,000.00.

The State Education Campaign Committee has plans to enlarge its service and has requested \$5,000.00.

The Association's Committee on Legislation and Public Policy which is more active than heretofore will need approximately \$4,000.00.

The Annual Meeting of the A.M.A. next June will be held in San Francisco. The extra traveling expenses for the Association's two delegates will be increased \$500.00 above last year.

The supervisor of the Association's Bureau of Public Relations is spending the larger portion of his time in the field so at the present schedule additional traveling expenses will be needed.

State sales tax is something new and will require approximately \$700.00.

Dissolving the Academy of Public Medicine and putting the Public Relations Bureau in the Association's general office increased the combined personnel to such an extent that State Unemployment Compensation must be paid and will approximate \$950.00—more if retroactive.

Increased activities in the office and in the field will require more money for postage, supplies, telephone, telegraph, printing, engraving, etc.; the estimate is \$2,525.00.

Additional revenue of \$20,000.00 is therefore needed. A \$15.00 increase in annual dues will bring in approximately \$27,840.00 and leave a balance of \$7,840.00.

The backlog carried in the Association's checking account has been practically wiped out. The approximate budget for the ensuing year will be \$94,817.24. With activities requiring this amount it would not seem to be good business to use up all cash backlogs. If the increase in dues is approved by the House of Delegates, there will be a surplus of \$7,840.00 to replace a part of the surplus that has been used, and to permit the Board of Governors to meet unexpected emergencies.

Bureau of Public Relations

The House of Delegates last year in Belleair voted that the services of the Academy of Public Medicine be discontinued and the Bureau of Public Relations be placed as a department in the general office.

Last October, Mr. Ernest R. Gibson was transferred to the general office as assistant to the managing director and Mr. Wm. Harold Parham was employed as supervisor of the Bureau.

The Bureau has worked principally with the Association's Committees on Public Relations, Legislation and Public Policy and State Education Campaign by assisting and carrying out details as requested.

Public relations activities have been continued by supplying radio stations with electrical transcriptions and newspapers with weekly health topics. During the last half of the fiscal year special emphasis has been placed on field work. Contacts with Association officers, members, radio stations, newspaper editors and influential individuals were made in the following cities: Apalachicola, Bartow, Bonifay, Brooksville, Chipley, Clewiston, Coral Gables, Crestview, Daytona Beach, DeFuniak Springs, DeLand, Ft. Lauderdale, Gainesville, Hollywood, Jacksonville, Lakeland, Live Oak, Lake City, Macclenny, Madison, Marianna, Miami, Monticello, Naples, Ocala, Orlando, Palatka, Panama City, Pensacola, Port St. Joe, Quincy, Ruskin, St. Petersburg, Sebring, Tallahassee, Tampa, Wewahatchka.

The Education Campaign has been continued by working diligently on resolutions against Socialized Medicine, distribution of campaign literature and coordination of information among county medical societies.

An Essay Contest approved by the Board of Governors on "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care" has been launched and every junior and senior high school in the state has been supplied with a packaged library kit.

The Second State Education Campaign Conference was held in March 1950. The majority of the county medical

societies were well represented and plans formulated for this year.

The Bureau has been a clearing house for correspondence, allied organizational relations and educational campaign material and is available at all times for information and assistance.

The Journal

During the past year, 27,652 Journals were printed. Collections from advertising approximately covered the actual printing costs of The Journal. This does not, however, include the services of the office personnel. Earnings from advertising, subscriptions, sale of Journals, etc. totaled \$14,214.90.

Dr. Shaler Richardson, the editor sets all policies for The Journal and the mechanical operations, etc. are supervised by Dr. Stewart Thompson, managing editor.

Medical Directory

The 1950 Florida Medical Directory was mailed to all members of the Association free of charge. Any member desiring an additional copy will be required to pay \$2.00.

It is hoped that the new cover will meet with general approval. The advertisement on the lower portion of the front cover is revenue producing, so the new cover was designed to include space for the advertisement and still not detract from the attractiveness of the cover.

The Directory was first compiled and published by the Association in 1938 and has continued each year without interruption.

The income from advertising and sales of Directories totaled \$1,372.00. The cost of printing, postage, engraving, etc. was covered by this income. This, of course, does not include supervision and the salaries of employees who worked on the Directory.

Association's Office

Your headquarters office is as busy as a bee hive. Many of the Association's officers and members have visited there. It is our hope that more of the members will find an opportunity to visit the office and obtain firsthand information as to what is required to keep up with the multitudinous activities.

The increased revenue now going to the A.M.A. has enlarged the activities in Chicago and, in turn, loads the state office with inquiries, questions, correspondence, literature, etc. It is surprising to note how much more work there is in the state office from this source, as well as expanded activities by the Association's new programs. Many of the county medical societies have independent activities and programs and your office is always interested in cooperating with them.

The question is often asked, "What is done in the office?" It cannot be answered in a few words with an honest answer. You are all engrossed with the duties of this Convention and could not spare the time to listen to a full answer. Dr. Payne, your president, made many trips to the office from his home in Pensacola. He would stay one day; sometimes two. In his capacity as the real head of the profession in the state, he came to analyze, weigh and reach decisions upon Association problems. During every visit he displayed eagerness to obtain more information about the activities of the Association and the headquarters office.

The reasons for not answering the question in this report are therefore obvious, and it is our desire that all members who are interested in the details pertaining to your Association's affairs will make personal visits to the office and receive firsthand information that is available.

Some of the leaders in the office staff who should receive commendation for faithful service are: Ernest R. Gibson, assistant managing director; Wm. Harold Parham, supervisor, Bureau of Public Relations; Mrs. Zoe Pack, chief clerk; also, Mrs. Edith B. Hill, manuscript editor who edits all manuscripts for scientific articles in The Journal and assists in the Editorial and Commentary sections.

Finances

In the beginning of this report we commented on finances and will undoubtedly furnish as much detail as you wish to hear read.

The financial statements appearing at the end of this report will be published in the June Journal for the benefit of members who wish to study the details.

The books and records of the Association are open to the members and we will be glad to answer inquiries of any nature upon request. The books have been audited by Charles H. Goodrich, Certified Public Accountant and a certification of the audit is incorporated in the statements which follow.

Respectfully submitted,
Robert B. McIver, *Secretary-Treasurer*
Stewart G. Thompson, *Managing Director*

Consolidated Cash Statement

March 16, 1949 through March 20, 1950

<i>Receipts</i>		
Cash shown in Bank, March 16, 1949	\$40,289.18	
Less Retirement Trust Fund March 16, 1949	8,172.32	\$ 32,116.86
Dues and Entrance Fees Collected (Exhibit "D")	\$48,585.00	
Earnings From Journal Advertising (Exhibit "B")	13,977.28	
Subscription and misc. sale of Journal (Exhibit "B")	224.75	
Earnings from Directory Advertising (Exhibit "E")	910.00	
Directory Sales (Exhibit "E")	462.00	
Interest on Savings and Investment	18.68	
Miscellaneous Income	134.98	
Profit from Reprints (Non-Members)	12.87	
Earnings from Technical Exhibits (Exhibit "C")	7,945.00	
Income from Smoker	1,893.00	
Miscellaneous Income — Bureau of Public Relations — For Advertising, etc.	765.00	
Transferred from Academy of Public Medicine	2,093.32	77,021.88
Total Cash to be Accounted for		\$109,138.74
<i>Disbursements</i>		
General Fund Expenses (Exhibit "A")	\$ 5,443.66	
Journal Expenses (Exhibit "B")	12,282.91	
Directory Expenses (Exhibit "E")	1,334.70	
Technical Exhibit Expenses (Exhibit "C")	4,437.11	
Committee Expenses (Exhibit "A")	313.45	
Federal Tax	333.60	
Sales Tax	131.55	
Library	134.28	
Furniture and Fixtures	294.34	
Bureau of Public Relations	19,300.43	
Payrolls	21,248.10	
Contractor Fees	1,428.32	
Retirement Trust Fund	3,600.00	
To Entertaining Society (Hillsborough-Pinellas)	2,075.35	72,357.80
Balance in Bank, March 20, 1950		\$ 36,780.94

Assets and Liabilities

March 20, 1950

<i>Assets</i>	
Cash in Fla. Natl. Bank Checking Acct.	\$ 34,888.42
Cash in Barnett Natl. Bank Checking Acct. (Postgraduate Course Committee Acct.)	646.58
General Fund — Accounts Receivable	14,600.00
Journal Fund — Accounts Receivable	1,013.27
Furniture, Fixtures and Equipment (less depreciation)	2,505.41
B.P.R. Furniture, Fixtures and Equipment (less depreciation)	1,866.01
Library	1,279.95
Stationery Inventory	1,028.01
Atlantic Natl. Bank (Retirement Trust Fund)	11,972.84
Savings: Atlantic Natl. Bank	9.17
Barnett Natl. Bank	1,883.35
Investments: Treasury Bond	14,800.00
War Savings Bonds	15,040.50
	<hr/>
	\$101,533.51
<i>Liabilities</i>	
Bureau of Public Relations	\$ 13,662.12
Postgraduate Course Committee	646.58
Capital	87,224.81
	<hr/>
	\$101,533.51

Exhibit "B"**Cash Statement — Journal Fund**

March 16, 1949 through March 20, 1950

<i>Receipts</i>		
Cash as per last audit	\$	0.00
Earnings from Advertising	\$13,977.28	
Subscription and Misc. Sale	224.75	
Profit from Reprints (Non-Members)	12.87	14,214.90
To be accounted for		\$14,214.90
<i>Disbursements</i>		
Postage and Supplies	\$ 446.39	
Printing and Stock	11,417.52	
Telephone and Telegraph	236.83	
Dray	51.50	
Express	3.10	
Engraving, Art Work, etc.	118.85	
Incidental	8.72	
	<hr/>	\$12,282.91
To General Fund (Income above Cost)	1,931.99	\$14,214.90
Cash Balance		\$ 0.00

Exhibit "F"**Retirement Trust Fund****Analysis of Changes**

March 16, 1949 to March 20, 1950

Balance on hand March 16, 1949	\$ 8,172.32
Additions	
Transfers from General Fund	\$3,600.00
Income:	
Gross Interest on Bonds	\$237.50
Less:	
Accrued Interest Paid on Purchases	\$27.46
Income Tax Paid	9.52 36.98 200.52
Net Additions	3,800.52
Balance on hand March 20, 1950	\$11,972.84

Exhibit "A"**Cash Statement — General Fund**

March 16, 1949 through March 20, 1950

Receipts

Cash shown as per last audit . . .	\$40,289.18	
Less Retirement Trust Fund		
March 16, 1949	8,172.32	\$32,116.86
Back Dues Collected (Exhibit "D")	\$15,125.00	
Current Dues Collected (Exhibit "D")	31,800.00	
Entrance Fees Collected (Exhibit "D")	1,660.00	48,585.00
Interest on Savings and Investment	18.68	
Miscellaneous Income	134.98	
From Journal Fund (Income above Cost)	1,931.99	
From Directory Fund (Income above Cost)	37.30	
From Exhibit Fund (Income above Cost)	3,325.54	
Bureau of Public Relations	2,858.32	
Total Cash to be Accounted For		\$89,008.67

Disbursements

Postage and Supplies . . . \$	999.72	
Telephone and Telegraph	537.11	
Traveling Expense	754.34	
Delegates' (2) Transp. Atlantic City and Washington	207.34	
Office Rent	2,260.00	
Towel Service	18.00	
Porter Service	33.75	
Express and Freight	3.33	
Bank Exchange	6.82	
Custody of Bonds	50.00	
Clipping Service	70.00	
Treasurer's Bond	37.50	
Employer's Liability Insurance	27.12	
Subscription — Times- Union	18.20	
Repair & Service on Furn., Fix., & Equipment	227.30	
Rental — Safety Deposit Box	15.00	
Blue Cross and Blue Shield	103.10	
Incidental	12.09	
Literature	8.00	
Photostats	28.94	
Past President Pins	26.00	5,443.66
Committees:		
Council	192.41	
Board of Governors	110.33	
Scientific Work	10.71	313.45

Bureau of Public Relations (B.P.R. Exhibit)	19,300.43	
Federal Tax	333.60	
State Tax	131.55	
Furniture and Fixtures	294.34	
Library	134.28	
Payrolls*	21,248.10	
Contractor Fees	1,428.32	
Retirement Trust Fund	3,600.00	\$52,227.73

Cash Balance \$36,780.94

*Total Payroll. Income tax deducted from this amount
and paid to Collector of Internal Revenue.**Exhibit "C"****Cash Statement — Exhibit Fund**

March 16, 1949 through March 20, 1950

Receipts

Cash as per last audit	\$	0.00
Earnings from Technical Exhibits	7,945.00	
Earnings from Smoker Receipts	1,893.00	
To be Accounted for		\$9,838.00

Disbursements

Convention Expense:		
Telephone and Telegraph	\$	157.62
Exhibit Booth Equipment	2,036.50	
Honorarium — Guest Speaker	172.80	
Programs	259.60	
Badges	156.17	
Misc. Expense and Employees' Travel	80.35	
News Service, Cuts and Mats	87.91	
Proceedings Reporter	70.00	
Annual Dinner Speaker, etc.	109.99	
Printing and Stock	26.20	
Hotel Service — Employees and Guest Speaker	1,000.11	
Projector Equipment and Operator	241.45	
Postage	30.06	
Incidental	8.35	
		4,437.11
To Entertaining Societies (Hillsborough-Pinellas)	2,075.35	
To General Fund (Income above Cost)	3,325.54	9,838.00
Cash Balance	\$	0.00

Exhibit "E"**Cash Statement — Directory Fund**

March 16, 1949 through March 20, 1950

Receipts

Cash as per last audit		0.00
Earnings from Advertising	\$	910.00
Sales	462.00	\$1,372.00
To be Accounted for		\$1,372.00

Disbursements

Postage and Supplies	\$	99.00
Printing and Stock	1,192.20	
Telephone and Telegraph . . . . .	.70	
Incidental	2.00	
Engraving and art work	40.80	
		\$1,334.70
To General Fund (Income above Cost)	37.30	\$1,372.00
Cash Balance	\$	0.00

Exhibit "D"

Dues and Entrance Fees Collected March 16, 1949 Through March 20, 1950

Name of Society	Total Members	No. Paid Members	No. In Arrears	1950 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	43	40	3	850.00	225.00	80.00
Bay	16	12	4	250.00	200.00	10.00
Brevard	17	17	0	375.00	25.00	40.00
Broward	70	59	11	1,275.00	250.00	90.00
Columbia	17	16	1	375.00		10.00
Dade	529	318	211	7,400.00	5,500.00	470.00
DeSoto-Hardee-Highlands-Charlotte-Glades	28	22	6	475.00	50.00	10.00
Duval	247	143	104	2,900.00	1,800.00	200.00
Escambia	64	8	56		1,400.00	50.00
Franklin-Gulf	6	1	5		50.00	10.00
Hillsborough	153	127	26	2,775.00	1,575.00	40.00
Indian River	7	7	0	150.00		10.00
Jackson	18	13	5	250.00	75.00	10.00
Lake	22	21	1	475.00	475.00	20.00
Lee	23	21	2	475.00	75.00	10.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	47	43	4	925.00	200.00	40.00
Madison	4	1	3		25.00	
Manatee	20	5	15	100.00	475.00	20.00
Marion	28	26	2	525.00	100.00	30.00
Monroe	12	10	2	200.00		
Nassau	9	9	0	175.00		
Orange	134	111	23	2,575.00	750.00	110.00
Palm Beach	96	73	23	1,750.00	525.00	50.00
Pasco-Hernando-Citrus	12	10	2	200.00	50.00	10.00
Pinellas	167	163	4	3,675.00	125.00	110.00
Polk	82	56	26	1,300.00	375.00	90.00
Putnam	10	9	1	200.00		
St. Johns	14	13	1	250.00		
St. Lucie-Okeechobee-Martin	12	9	3	200.00		10.00
Sarasota	24	4	20		525.00	40.00
Seminole	12	12	0	250.00	25.00	10.00
Suwannee	7	7	0	150.00	25.00	20.00
Taylor	3	3	0	50.00		
Volusia	59	39	20	825.00	200.00	50.00
Walton-Okaloosa	15	15	0	325.00	25.00	10.00
Washington-Holmes	5	5	0	100.00		
Totals	2,032	1,448	584	31,800.00	15,125.00	1,660.00
Dues Not Payable				15,125.00	Back Dues Collected	
Co. Soc. Secys.	36					
Life	81			46,925.00	Total Dues Collected	
Honorary	47			1,660.00	Entrance Fees Collected	
Military Service	12	176				
Paying Dues		1,272				
				\$48,585.00	Dues and Entrance Fees	

Dr. Robert B. McIver
Secretary-Treasurer
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Stewart G. Thompson, Managing Director, we have examined the following:

Statement of Assets and Liabilities — March 20, 1950.
Consolidated Cash Statement — March 16, 1949 to March 20, 1950.

Exhibits A to F inclusive.

Statement of Receipts and Disbursements — Bureau of Public Relations — March 16, 1949 thru March 20, 1950.

Statement of Receipts and Disbursements — Medical Postgraduate Course-V — March 16, 1949 thru March 20, 1950.

all of Florida Medical Association, Inc.

These statements and exhibits have been found in agreement with the books of account of the Association and correctly reflect the recorded cash transactions for the period.

All recorded receipts covering cash collections were traced to the bank deposits and all bank balances have been reconciled with the books of account and independently verified by the depositories.

Cancelled checks covering disbursements were checked to the records, found in order and appeared to be for proper purposes.

War Bonds of a maturity value of \$40,325.00 were verified by inspection.

No attempt was made to verify remittances for dues, on account of the inaccessibility of the records of the various County Societies.

Yours very truly,

CHG/d

(Signed) Goodrich & Varnedoe
Certified Public Accountants

Bureau of Public Relations — IV

March 16, 1949 through March 20, 1950

Receipts

Cash Balance	\$12,700.00
Dues Collected 1949 — \$15,125.00; 1950 — \$31,800.00, Total \$46,925.00 (Exhibit "D")	
Two-Fifths — 1,877 @ \$10.00	18,770.00
Miscellaneous Income for Advertising, etc.	765.00
Cash Transferred from Academy of Public Medicine	2,093.32
Total cash to be accounted for	\$34,328.32

Disbursements

Payrolls	\$ 9,993.20
Rent	1,088.00
Postage	728.76
Printing, Engraving, etc.	1,238.06
Telephone and Telegraph	918.97
Supplies	350.69
Traveling Expense	2,504.90
Furniture, Fixtures and Equipment	760.76
Federal Tax	252.68
State Tax	27.37
Clipping Service	110.00
Special Service	59.61
Express and Freight	136.39
Blue Cross and Blue Shield	28.70
Repair and Service	12.00
Porter Service	35.13
Attorney Fees (For Dissolution of Academy of Public Medicine)	91.01
Advertising — Woman's Club Magazine, etc.	788.20
Education Committee Conference	155.00
Incidental	21.00
Cash Disbursements	19,300.43
Service Charge — General Office for Public Relations Bureau	3,314.11
Exhibit Space Rental — Belleair	125.00
Cash Balance	\$11,588.78
Furniture, Fixtures and Equipment Transferred from Academy of Public Medicine (Value)	\$1,312.58
Purchased during year	760.76
Total Value	\$2,073.34

Medical Postgraduate Course Committee — VIII

March 16, 1949 through March 20, 1950

Receipts

Cash as per last audit	\$ 991.58
Registration Fees, etc., 1949 Postgraduate Course	2,655.00
To be Accounted for	\$3,646.58

Disbursements

Dr. T. Z. Cason, Chairman-Expenses	\$3,000.00
Balance in Bank	\$ 646.58

Due to illness in the immediate family of Dr. Shaler Richardson, editor, his report was read as follows by Dr. Webster Merritt, the assistant editor.

Report of Editor of The Journal**Dr. Shaler Richardson**

Thirty-six years of continuous progress and steady improvement is the record The Journal presents with pride as it prepares to complete the current year of publication with the June issue. The staff believes that more than a third of a century of constant effort to make The Journal rate with the best in its field has been most fruitful and that, today, your journal can take its rightful place among similar publications.

I have been privileged to be associated closely with the growth of The Journal. I am proud to have had a part in its development. Twenty-five years ago you elected me editor and I have served in that capacity to the best of my ability the entire quarter-century, with the exception of two years as president-elect and one year as president.

Circulation figures now show a total of 2,239, which is the largest number in our history of over a third of a century. Of these 2,028 go to active members of the Association, the remainder being distributed among individual subscribers, advertisers and exchanges. Increased circulation automatically adds to the publishing costs, which still remain at the all-time high brought about by war and postwar conditions.

The Journal has published 55 scientific papers during the past year, 49 by members and 6 by guest authors. Papers read before the scientific sessions of the annual meeting at Belleair account for 19 of the total used, and which were given just priority in the publication schedule. Other articles were submitted by members, as original presentations of unpublished papers.

Other journals are scanned for articles published by our members. The author is then contacted for verification and permission to abstract his article. Last year 76 abstracts were published.

An editorial policy of commenting on matters which are timely, informational and of interest to the members is being continued. As a sign of the times you have found that many columns have been used in the battle to keep medical practice in this country free from government control. However, there has been an honest effort to avoid monotonous harping on a few subjects. I believe that you have found the editorial and commentary pages sufficiently diversified to be worth reading. The scientific problems have not been neglected as you have witnessed in some fine editorials for which we are indebted, in most instances, to the able pen of the assistant editor, Dr. Webster Merritt. My versatile assistant does not restrict himself exclusively to the strictly scientific problems, but whatever the subject we can be certain that it has been thoroughly studied and analyzed and that his conclusions are amply justified by the facts.

The popular sections of state news items and county society notes remain an important part of The Journal. These could be even more valuable and informative with greater contributions from members. The staff searches diligently for news but there must be many items of interest which escape attention and therefore are never published.

There are other features of note such as the sections on Your Blue Shield, the State Board of Health and Book Reviews. For your convenience there is a list of Association officers and committee members, a schedule of meetings of certain medical organizations, and a tabulation of the county societies, together with their presidents, secretaries, meeting dates and current membership.

I particularly want to take this opportunity to express appreciation to the associate editors as well as to Dr. Merritt, that is, to Drs. J. Rocher Chappell, C. Frank

Chunn, Carlos P. Lamar, James H. Pound and Wilson T. Sowder. The assistance of Dr. Chas. J. Collins and Dr. James N. Patterson, the other members of the Committee on Publication, have been invaluable. One or both of these members read and edited every scientific article published in *The Journal* before it was finally referred to me. This takes time and effort which should merit the special appreciation of the membership.

Without the aid of the abstract chairman, Dr. Kenneth A. Morris and his able helper, Dr. Walter C. Jones, that part of *The Journal* would function much less smoothly.

My warmest personal appreciation goes to Dr. Stewart Thompson, managing editor, who has given more than twenty-four years faithful service on *The Journal*. Special mention also goes to Mrs. Edith B. Hill, manuscript editor, who goes over all scientific papers before they are sent to the printer. In addition she works on editorials and commentaries.

Remember that *The Journal* is a fairly accurate reflection of the medical progress in the state. The bigger and better you help it to become the greater the service it will be able to perform for the medical profession.

Respectfully submitted,
Shaler Richardson, *Editor*

There were no delegates present from other state societies.

There being no further business or announcements, the Second General Session adjourned.

Third General Session

The meeting of the Florida Medical Association reconvened at 11:35 a.m., Tuesday, April 25, in the Hollywood Beach Hotel; President Payne in the Chair.

The meeting was called to order.

The guest speaker, Dr. Alton Ochsner, Director of the Section on General Surgery, Ochsner Clinic, New Orleans, was introduced by President Payne.

Dr. Alton Ochsner, today a most esteemed citizen of New Orleans, first greeted this world in Kimball, South Dakota. His early education was received in the schools of that state including academic training at the University of South Dakota. His medical degree came from the Washington University School of Medicine in St. Louis.

Our distinguished guest, giving early evidence of an interest in surgery, was privileged to serve a surgical internship under Dr. A. J. Ochsner, his uncle, at Augustana Hospital in Chicago. Later he served as exchange surgical assistant at medical institutions in Switzerland and Germany.

Although Dr. Ochsner began practice in Chicago in 1925, he shortly accepted a teaching position as Instructor in Surgery and Surgical Pathology at Northwestern University Medical School. From there he went to the University of Wisconsin Medical School, and later to Tulane where he still serves as Professor of Surgery and chairman of the department.

Eight years ago a dream became a reality with the founding of the Ochsner Clinic in New Orleans. Today that clinic is internationally known, a tribute to the foresight, courage and perseverance of the man who has graciously consented to be our 1950 convention guest speaker.

Dr. Ochsner not only is an active member of many medical societies in the United States but holds honorary memberships in a number of medical organizations in Central and South America. He is a distinguished author as well as an eminent surgeon. His pen as well as his scalpel has contributed greatly to the progress of medicine. Currently he is editor of the *International Surgical Digest* and coeditor of *Surgery*.

When Dr. Ochsner stepped to the rostrum, the assembly rose in a body and applauded.

Address: "Prevention of Venous Thrombosis Based on New Concepts of Blood Coagulation" by Dr. Ochsner.

President Payne expressed appreciation of the Florida Medical Association to Dr. Ochsner for his outstanding presentation.

There being no further business or announcements, the Third General Session adjourned at 12:20 p.m.

HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 9:35 a.m., Tuesday, April 25, 1950, in The Sun Room of the Hollywood Beach Hotel, Hollywood. Dr. Walter C. Payne, President, in the Chair.

Dr. Edward Jelks, chairman of the Credentials Committee, was recognized and reported 107 delegates whose credentials were in order.

The Chair stated that a quorum was present.

Dr. William M. Rowlett moved that the delegates be seated.

Motion seconded and carried.

Delegates

ALACHUA—John E. Maines, Jr., Thomas A. Snow
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Donald H. Gahagen, Richard A. Mills, Leigh F. Robinson
COLUMBIA—Thomas H. Bates
DADE—Herman Boughton, Charles R. Burbacher, Turner E. Cato, Jack Q. Cleveland, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Carl E. Dunaway, Herbert Eichert, Willard L. Fitzgerald, Richard M. Fleming, Edward F. Fox, Ralph W. Jack, Walter C. Jones, Carlos P. Lamar, A. Buist Litterer, Donald F. Marion, John D. Milton, Frazier J. Payton, Homer L. Pearson, Jr., James H. Putman, Warren W. Quillian, Donald W. Smith, Franz H. Stewart, Joseph S. Stewart

DeSOTO - HARDEE - HIGHLANDS - CHARLOTTE
GLADES—Hubert W. Coleman
DUVAL—John A. Beals, James L. Borland, Edward
Canipelli, Turner Z. Cason, Samuel M. Day, Jr., Frank
L. Fort, A. Judson Graves, Karl B. Hanson, Charles
F. Henley, Edward Jelks, Raymond R. Killinger, Web-
ster Merritt
ESCAMBIA—Herbert L. Bryans, Alvin L. Stebbins, Alvin
W. White
FRANKLIN-GULF—(*Absent—Albert L. Ward*)
HILLSBOROUGH—Chas. W. Bartlett, William C. Blake,
Leland F. Carlton, C. Frank Chunn, Herschel G. Cole,
Joshua C. Dickinson, Samuel G. Hibbs, William M.
Rowlett
INDIAN RIVER—James C. Robertson
JACKSON—Redden L. Miller
LAKE—(*Absent—Leroy H. Oetjen*)
LEE—William H. Grace
LEON - GADSDEN - LIBERTY - WAKULLA - JEF-
FERSON—J. Lloyd Massey, Bricey M. Rhodes
MADISON—(*Absent—Julian M. DuRant*)
MANATEE—Willis W. Harris
MARION—John N. Moore
MONROE—Ralph Herz
NASSAU—Cecil B. Brewton
ORANGE—Chas. J. Collins, Horace A. Day, Eugene L.
Jewett, Duncan T. McEwan, Louis M. Orr, II, Frank
J. Pyle
PALM BEACH—Charles McD. Harris, Jr., V. Marklin
Johnson, Ralph M. Overstreet, Jr., Bailey B. Sory, Jr.,
Vale D. Stone
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—William M. Davis, John P. Ferrell, Albert
R. Frederick, N. Worth Gable, Francis H. Langley,
Alvin L. Mills, John P. Rowell, Walter H. Winchester
POLK—Jere W. Annis, James R. Boulware, Jr., Robert
J. Jahn, Wiley T. Simpson
PUTNAM—Lawrence G. Hebel
ST. JOHNS—A. Clark Walkup
ST. LUCIE-OKEECHOBEE-MARTIN—Henry E. Branca
SARASOTA—Hugh G. Reaves
SEMINOLE—Frank L. Quillman
SUWANNEE—John N. Sims
TAYLOR—Walter J. Baker
VOLUSIA—C. Robert DeArmas, Hugh West, J. Richard
West
WALTON-OKALOOSA—William D. Cawthon
WASHINGTON-HOLMES—(*Absent—L. H. Paul*)
ASSOCIATION OFFICERS—Walter C. Payne, Herbert
E. White, David R. Murphey, Jr., M. Eldridge Black,
John M. Butcher, Robert B. McIver, (*Absent—Shaler
Richardson*)

On motion by Dr. Leland F. Carlton, seconded
by Dr. William C. Blake, the minutes as pub-
lished in the June 1949 Journal were approved.

The Chair called for election of one delegate
to the A.M.A. to serve a two year term beginning
January 1, 1951 and ending December 31, 1952.

Dr. Homer L. Pearson, Jr., was nominated by
Dr. Stebbins. Dr. Merritt moved that nomina-
tions be closed and the Secretary cast the ballot
for Dr. Pearson.

Motion seconded and carried.

Dr. Pearson was elected delegate to succeed
himself.

The Chair called for election of one alternate
delegate to the A.M.A. to serve a two year term
beginning January 1, 1951 and ending December
31, 1952.

Dr. Frank D. Gray was nominated by Dr.
James L. Borland. It was moved that nomina-
tions be closed and the Secretary cast the ballot
for Dr. Gray.

Motion seconded and carried.

Dr. Gray was elected alternate for Dr. Pear-
son.

The Chair announced the personnel of the
three reference committees as follows:

1. HEALTH AND EDUCATION

Ladies' Card Room
Jere W. Annis, *Chairman*
Alvin L. Stebbins
Warren W. Quillian
David R. Murphey, Jr.
Webster Merritt

2. PUBLIC POLICY

S. W. Porch
William M. Rowlett, *Chairman*
Francis H. Langley
Donald W. Smith
Bricey M. Rhodes
John E. Maines, Jr.

3. FINANCE AND ADMINISTRATION

Men's Card Room
Walter C. Jones, *Chairman*
Robert B. McIver
Duncan T. McEwan
Herbert E. White
Herbert L. Bryans

The Chair announced that resolutions from
the floor would be heard at this time.

Dr. William C. Roberts presented a resolution
that all past presidents of the Association be made
lifetime members of the House of Delegates. This
was referred by the Chair to Reference Committee
No. 2, Public Policy.

Dr. Herschel G. Cole presented a resolution
regarding expansion of the State Board of Health.
This was referred by the Chair to Reference Com-
mittee No. 2, Public Policy.

Dr. Thomas C. Kenaston presented a resolu-
tion regarding fees for expert medical testimony.
This was referred by the Chair to Reference Com-
mittee No. 3, Finance and Administration.

Dr. Jack Q. Cleveland presented a resolution
concerning institutions charging fees for doctors'
services and regarding the Hess report. This was
referred by the Chair to Reference Committee
No. 2, Public Policy.

Dr. V. Marklin Johnson presented a resolution
relative to the taking of fees by unlicensed doc-
tors. This was referred by the Chair to Refer-
ence Committee No. 2, Public Policy.

Dr. Hubert W. Coleman presented a resolu-
tion regarding a doctor being sent to the Ameri-

can College of Surgeons. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Marion County Medical Society Resolution — Special license plates for M.D.'s (Handbook) to Reference Committee No. 2.

Leon - Gadsden - Liberty - Wakulla - Jefferson County Medical Society Resolution — Brief Doctors appearing before Legislative Committees (Handbook) to Reference Committee No. 2.

Dr. Walter C. Payne's Resolution — F.M.A. Grievance Committee (Handbook) to Reference Committee No. 3.

Dr. Walter C. Payne's Resolution — County Medical Society Mediation Board (Handbook) to Reference Committee No. 3.

Leon - Gadsden - Liberty - Wakulla - Jefferson County Medical Society Resolution — Change date of Annual Meeting of F.M.A., etc. (Handbook) to Reference Committee No. 3.

The Chair referred Annual Reports of standing committees (Handbook) as follows:

(To Reference Committee No. 1)

Annual Reports

Scientific Work, Frederick K. Herpel
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Lloyd J. Netto
Venereal Disease Control, Roger F. Sondag
Tuberculosis and Public Health, Erasmus B. Hardee*
Maternal Welfare, Lowrie W. Blake
Child Health, Egbert V. Anderson

**Supplemental report presented and referred*

(To Reference Committee No. 2)

Annual Reports

Conservation of Vision, Joseph W. Taylor
Legislation and Public Policy, Eugene G. Peek
Medical Education and Hospitals, Bascom H. Palmer
Public Relations, Joseph S. Stewart
Medical Economics, Herbert W. Virgin, Jr.
State Controlled Medical Institutions, James G. Lyerly
Representatives to Industrial Council, G. Frederick Oetjen

(To Reference Committee No. 3)

Annual Reports

Board of Governors, Walter C. Payne
Interrelationship, Henry J. Peavy*
Necrology, Joseph Halton*
Advisory to Woman's Auxiliary, Edward F. Shaver
Councilor Districts and Council, Russell B. Carson
**Supplemental report presented and referred*

There being no further business, the House recessed at 11:00 a.m. to reconvene at 10:30 a.m., Wednesday, April 26, 1950.

Second House of Delegates

The House of Delegates reconvened at 10:45 a.m., Wednesday, April 26 in The Sun Room of the Hollywood Beach Hotel, Hollywood; President Payne in the Chair.

Dr. Edward Jelks, Chairman of the Credentials Committee, was recognized and reported that there were 106 delegates present.

Dr. Payne: "There being a quorum, I declare the second session of the House of Delegates in session."

Delegates

ALACHUA—John E. Maines, Jr., Thomas A. Snow
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Donald H. Gahagen, Richard A. Mills, Leigh F. Robinson
COLUMBIA—Thomas H. Bates
DADE—Herman Boughton, Charles R. Burbacher, Turner E. Cato, Jack Q. Cleveland, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Carl E. Dunaway, Herbert Eichert, Willard L. Fitzgerald, Richard M. Fleming, Edward F. Fox, Ralph W. Jack, Walter C. Jones, Carlos P. Lamar, A. Buist Litterer, Donald F. Marion, John D. Milton, Frazier J. Payton, Homer L. Pearson, Jr., James H. Putman, Warren W. Quillian, Donald W. Smith, Franz H. Stewart, Joseph S. Stewart
DeSOTO - HARDEE - HIGHLANDS - CHARLOTTE-GLADES—Hubert W. Coleman
DUVAL—John A. Beals, James L. Borland, Edward Canipelli, Turner Z. Cason, Samuel M. Day, Jr., Frank L. Fort, A. Judson Graves, Karl B. Hanson, Charles F. Henley, Edward Jelks, Raymond R. Killinger, Webster Merritt
ESCAMBIA—Herbert L. Bryans, Alvin L. Stebbins, Alvyn W. White
FRANKLIN-GULF—(Absent—Albert L. Ward)
HILLSBOROUGH—Charles W. Bartlett, William C. Blake, Leland F. Carlton, C. Frank Chunn, Herschel G. Cole, Joshua C. Dickinson, Samuel G. Hibbs, William M. Rowlett
INDIAN RIVER—James C. Robertson
JACKSON—Redden L. Miller
LAKE—(Absent—Leroy H. Oetjen)
LEE—William H. Grace
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—J. Lloyd Massey, Bricey M. Rhodes
MADISON—(Absent—Julian M. DuRant)
MANATEE—Willis W. Harris
MARION—John N. Moore
MONROE—Ralph Herz
NASSAU—(Absent—Cecil B. Brewton)
ORANGE—Chas. J. Collins, Horace A. Day Eugene L. Jewett, Duncan T. McEwan, Louis M. Orr, II, Frank J. Pyle
PALM BEACH—Chas. McD. Harris, V. Marklin Johnson, Ralph M. Overstreet, Jr., Vale D. Stone, (Absent—Bailey B. Sory, Jr.)
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—William M. Davis, John P. Ferrell, Albert R. Frederick, N. Worth Gable, Francis H. Langley, Alvin L. Mills, John P. Rowell, Walter H. Winchester
POLK—Jere W. Annis, James R. Boulware, Jr., Robert J. Jahn, Wiley T. Simpson
PUTNAM—Lawrence G. Hebel
ST. JOHNS—A. Clark Walkup
ST. LUCIE-OKEECHOBEE-MARTIN—Henry E. Branca
SARASOTA—Hugh G. Reaves
SEMINOLE—Frank L. Quillman
SUWANNEE—John N. Sims
TAYLOR—Walter J. Baker

VOLUSIA—C. Robert DeArmas, Hugh West, J. Richard West
WALTON-OKALOOSA—William D. Cawthon
WASHINGTON-HOLMES—L. H. Paul
ASSOCIATION OFFICERS—Walter C. Payne, Herbert E. White, M. Eldridge Black, David R. Murphey, Jr., John M. Butcher, Robert B. McIver, (*Absent—Shaler Richardson*)

Dr. Payne: "We have a telegram addressed to Drs. McIver, Thompson and me from Mr. C. P. Loran, secretary of the Southern Medical Association, 'Greetings. Hope you are having a most successful annual meeting.'"

Dr. Payne: "We also have a telegram addressed to Dr. William C. Thomas and signed by Dr. Lucien Y. Dyrenforth, 'Please extend invitation to attend Blood Bank Meeting May 13th to all physicians.'"

Dr. Payne: "This meeting which will be held at Ponte Vedra Beach will be interesting not only to those who are directly interested in blood bank work but to all physicians."

Report of Reference Committee No. 1

Dr. Jere W. Annis, chairman of Reference Committee No. 1, Health and Education, was recognized and asked to present the recommendations of that committee.

Dr. Annis: "The Committee on Health and Education met yesterday, all members present, and submit the following recommendations: The committee read the reports and recommends the approval of the Report of the Committee on Scientific Work, Report of the Committee on Medical Postgraduate Course, Report of the Committee on Cancer Control, Report of the Committee on Venereal Disease Control, Report of the Committee on Maternal Welfare and Report of the Committee on Child Health."

Dr. Annis: "I move these reports be adopted."
Seconded by Dr. Rowlett. Motion carried.

Report of Committee on Scientific Work

Frederick K. Herpel, *Chairman*

The Scientific Program for the 1950 annual meeting will present eighteen scientific papers before the four Scientific Assemblies. An attempt has been made by your committee to present a balanced program by physicians from all sections of the state.

Four distinguished speakers from outside Florida will present papers on the program, through the courtesy and cooperation of specialty groups.

Response to invitations issued early in the year to each of the specialty groups, and to all presidents of component medical societies of the state association did not produce the number of applications for places on the scientific program which the committee would have liked to have received.

A meeting of the full committee on December 4th, resulted in the selection of papers for presentation. Your chairman wishes to express his appreciation for the co-

operation of the members of the committee, and to all others who have contributed to this program.

It is recommended that for future committees there be sought a closer cooperation by the various specialty groups, to insure a balanced program, and representation of these specialty groups. It is also recommended that the president of each component medical society be considered an ex-officio member of this committee.

Having served now for several years on this committee it is felt that there should be at least one paper submitted from each unit of 50 members for consideration by the committee in choosing the program. The committee should have a wide range of papers, from all sections of the state, for its consideration.

Additional papers remaining after final selection of papers for the program would be available for submission to the editor of the Journal of the Florida Medical Association for possible publication throughout the year.

The recommendations above made look to the building up of the Journal, as well as simplification of the work of the committee in its preparation for future scientific programs.

Respectfully submitted,
Frederick K. Herpel, *Chairman*

Report of Committee on Medical Postgraduate Course

T. Z. Cason, *Chairman*

The Seventeenth Annual Graduate Short Course for doctors of medicine was held in Jacksonville, June 20-25, with a total attendance of 123 physicians.

A Special Course on Cardiovascular Diseases was held in Jacksonville June 14-17, which had an attendance of 58 physicians.

A Seminar on Tuberculosis was held in Orlando, May 11-13, with a total attendance of 45 physicians.

The faculty, location and outline of the programs for the preceding three courses, which were approved by the Medical Postgraduate Committee, were decided and prepared by the Department of Medicine of the Graduate School of the University of Florida.

A Seminar on Mycology was held in Orlando, April 23-25, with a total attendance of 30 physicians. A one day Seminar on Syphilis was held February 21-25, in various locations throughout the state. The attendance was 120 physicians in Miami, 50 in Tampa, 30 in Orlando, 40 in Jacksonville and 25 in Pensacola; total attendance 265 physicians. Both these courses were prepared by the Florida State Board of Health.

A Seminar on Diabetes was held in Jacksonville on March 28-29, with a total attendance of 167 physicians. This course was prepared by U. S. Public Health Service and the Florida State Board of Health.

The Medical Postgraduate Course Committee met at the George Washington Hotel, Jacksonville, October 16. All committee members were present. Also present were Dr. K. E. Miller, who represented the State Board of Health, and Dr. Frances E. M. Read of that same state agency.

At this meeting the functions of the Medical Postgraduate Course Committee in relation to the Department of Medicine of the University of Florida and to the Florida State Board of Health were discussed at the suggestion of Dr. Franz Stewart of Miami. It was then brought out that the committee as appointed by the Florida Medical Association acted in an advisory capacity to the Department of Medicine of the University of Florida and that the Board of Governors had decided upon this procedure as the best policy in order that the Florida Medical Association guide and direct medical educational programs for doctors of Florida. It was further brought out that the State Board of Health's funds to assist in medical educational programs are available only through authorized

channels and that the Department of Medicine of the University of Florida was the recognized channel for this type of program.

A Table of Organization was requested by the committee members and this was sent to each, together with a copy of the minutes of the meeting, a brief outline of the history of the short course and its ensuing programs, and a copy of the Faculty List of the Department of Medicine.

The Faculty List of the Department of Medicine was also discussed at the meeting and each member was requested to revise the list and to make new recommendations.

The part that the American Academy of General Practice could play in helping to increase the attendance at the courses was discussed at the meeting.

The instructors for the Short Course and the types of lectures were considered and the outlines of the courses were approved.

The manner in which the sponsoring agencies are to be listed on the programs were discussed and the type of preferred listing approved.

The Statement of Receipts and Disbursements, from July 1, 1948 to July 1, 1949, was presented at the meeting. It showed that receipts from registration fees were \$3,005.00, to which was added the Florida Tuberculosis and Health Association's assistance check of \$600.00, received November, 1948, making the total receipts \$3,605.00. The expenses for that same period, which do not include the expenses incurred by the U. S. Public Health Service for the Diabetes Seminar, amounted to \$4,859.33. This total includes funds amounting to \$525.32 paid out by the Florida State Board of Health to cover the honorarium and expenses for the pediatrician, gynecologist and obstetrician participating in the 1949 Short Course. The balance on hand on July 1, 1949, was \$1,417.71.

Respectfully submitted,
T. Z. Cason, *Chairman*

Report of Committee on Cancer Control

Lloyd J. Netto, *Chairman*

Your committee on Cancer Control has not found it necessary to call a formal meeting. Various members of the committee have served in their local communities with the established cancer clinics and other organizations active in cancer work throughout the state. Members have served at the request of your Chairman to represent him at meetings of various cancer units. Dr. Harold O. Brown represented the Chairman at a meeting of the Executive Committee of the American Cancer Society, Florida Division, held in Tampa on Saturday, January 21, 1950. Nothing came out of the meeting that should be included in this report.

Your committee has tried to keep in touch with what was going on in the state, particularly the activities carried on in the clinics supported by the American Cancer Society, Florida Division, and the Florida State Board of Health. The activities of these clinics as well as those independently operated in some of the larger cities indicate that the overall picture of cancer control in all of its phases is definitely improving.

On January 6, 1950, your Chairman spent most of the day in conference with Dr. Walter E. Batchelder who was then making a survey of the cancer facilities in Florida for the American College of Surgeons. A few quotes from his comments by letter will be offered in this report as follows: "The state-wide cancer program as is being carried out in Florida is to be commended. A very much needed service is being rendered to the people in a manner that you can be well proud of. Very high caliber men of your state have accepted the challenge, and are exhibiting a tremendous amount of interest in the entire problem."

Dr. Batchelder suggested that some type of assistance from a state-wide agency such as the medical association might be offered to help the smaller clinics get over the hurdles with the least friction during their organization period. During our conference the doctor suggested formation of a state-wide tumor clinic association which could meet two or three times a year; the meetings to be composed of one or more members from each established clinic to exchange ideas on all phases of the work. Your committee agrees that this might be a very desirable addition.

Another quote of importance: "I was particularly interested in the project sponsored by the Volusia County Health Department. I believe it is quite unique and deserves the attention of other such organizations."

Other discussions in the conference were not entirely agreeable in opinion inasmuch that they would take direct control out of the hands of the committee of the local medical society. More discussion will be held from time to time on these topics. It was agreed that there should be a cancer coordinating committee in the state consisting of members from the American Cancer Society, State Medical Association, and State Department of Health. Previous to this conference your chairman had discussed this with Dr. Ashbel Williams, Chairman of the Executive Committee of the American Cancer Society, Florida Division, who expects to have the current chairman of the Cancer Control Committee each year a member of the Executive Committee of the American Cancer Society, Florida Division, during his term of office.

An official letter from the College will be forwarded to the State Association when received.

It is the opinion of your committee that the cancer problem in the State of Florida is being handled with enthusiasm by high class men, and that the situation will improve from year to year.

Respectfully submitted,
Lloyd J. Netto, *Chairman*

Report of Committee on Venereal Disease Control

Roger F. Sondag, *Chairman*

For the first time since the close of the War in 1945, there was a decided decrease in the over-all number of reported cases of venereal diseases during 1949. During 1946, 1947 and 1948 there was a steady increase in the number of primary and secondary cases of syphilis, but during 1949 there was a marked decrease. During the early part of the year an excellent program on the diagnosis and treatment of syphilis was presented in Miami, Tampa, Orlando, Jacksonville and Pensacola by two outstanding teachers. The program was presented in various cities in order to make graduate instruction more readily available to practicing physicians. This instruction was arranged in cooperation with the Committee on Medical Post-graduate Courses.

During July and August a state-wide educational program was inaugurated to coincide with the National program in effect during those months. All sorts of educational publicity media were used; namely, radio, newspaper articles, literature, talks, car cards and planned programs before civic groups, churches and schools. This program is still in effect.

With the development of better repository types of penicillin, the in-patient treatment of syphilis will soon be out-moded. Each month during 1949, fewer cases were accepted for in-patient care at the Rapid Treatment Center. It is anticipated that soon all syphilis treatment will again be given on an out-patient, ambulatory basis.

The essence of venereal disease control still remains the same; finding venereal disease cases early, tracing their contacts, and adequate treatment under medical supervision.

Respectfully submitted,
Roger F. Sondag, *Chairman*

Report of Committee on Maternal Welfare

Lowrie W. Blake, *Chairman*

Your Committee on Maternal Welfare, in conjunction with the State Board of Health, is endeavoring to make a study of the cause of maternal deaths in the State of Florida. Prepared questionnaires are being sent to individual County Medical Societies over the entire State. It is hoped by this study that our maternal mortalities may be greatly reduced.

Several counties have already begun this investigation and it is hoped that soon all of the other Societies will take part.

Respectfully submitted,
Lowrie W. Blake, *Chairman*

Report of Committee on Child Health

Egbert V. Anderson, *Chairman*

During the past year your Committee on Child Health has spent much time and effort in a program aimed at coordination of various child health and welfare agencies and programs in the state. Specifically the Children's Commission, Florida Crippled Children's Commission, American Academy of Pediatrics, Florida Pediatric Association, Bureau of Maternal and Child Health of State Board of Health and the Committee on the Foetus and the Newborn.

The Committee held a meeting on October 30, 1949, in Orlando to discuss the subject of formation of a Children's Council by the Florida Medical Association in an effort to integrate efforts now being put forth in the field of child health and welfare. It was found that at the present the Children's Commission of the State is working on a plan based on the same idea plus the formulation of a directory to be made available containing all the programs at present in the State. After considerable discussion your Committee felt, for the present at least, that the plan of the Children's Commission should be encouraged and aided and the formulation by the Medical Association of a Children's Council should be delayed for the time being. At this same meeting the Committee discussed at length the program of the American Academy of Pediatrics as presented by Dr. James Boulware, State Chairman for the Academy of Pediatrics, and agreed to cooperate in any way possible in further results of the study which have been made by the Academy in this State and throughout the country. Also the Committee was presented with the plan for the program of the Florida Committee on the Foetus and Newborn. Cooperation was promised in carrying out their planned program to improve the infant mortality rate in our state which is still too high. Consideration was given to the proposed Cerebral Palsy Program of the State Crippled Children's Commission, but no action was taken since a committee from the Florida Pediatric Association had already been appointed to work on this program. This latter Committee made recommendations which were accepted by the Florida Pediatric Association of which all members of your Committee are members.

Much correspondence and personal contact has been had with the Bureau of Maternal and Child Health of the State Board of Health concerning the program for setting up premature centers throughout the State to reduce further the mortality rate in premature deaths. A number of suggestions have been made concerning this program also. Many agencies over the State are making a concerted effort to reduce the black and grey markets in the field of adoption in our State. Your Committee has cooperated and encouraged this program, for we feel that it is very important in many aspects at the present time. No specific recommendations have been made.

From the number of requests received by the Committee it is obvious that most agencies are very anxious for medical advice and guidance in the formulation of any of their programs. It is recommended therefore that every

effort be put forth by the Committee to satisfy this demand. In so doing we feel that the health of the child in Florida will be furthered greatly. Also it is felt that with medical guidance full benefit will be obtained from tax supported programs because of greater efficiency and more pointed activity with the elimination of some of the overlapping that is so obvious at present.

Your Committee has no recommendations for any new programs but a continuation of the study of and cooperation in those under way at present.

Respectfully submitted,
Egbert V. Anderson, *Chairman*

Dr. Annis: "The report and supplement of the Committee on Tuberculosis and Public Health was approved."

Dr. Annis: "I move that it be adopted."

Seconded by Dr. Herz. Motion carried.

Report of Committee on Tuberculosis and Public Health

E. B. Hardee, *Chairman*

The activities of this committee, during the past year, have been carried on largely through correspondence. We have kept close contact with the State Board of Health and with the Florida Tuberculosis and Public Health Association. Your Chairman or members of this committee have attended meetings of the Florida Tuberculosis and Public Health Association as well as Directors Meetings of the Florida Tuberculosis Association. This Committee worked closely with the members of the Committee on Legislation and Public Policy during the past year.

We are pleased to report that the Tuberculosis Hospital at Lantana will be ready to receive patients within the near future.

We bespeak your continued effort in procuring additional beds and finances for our Sanatoria in Florida.

Supplement

Representatives of the State Board of Health appeared before your committee to outline and to seek approval of the proposed program of the Division of Diabetes Control of the State Board of Health. This program was outlined as follows:

1. Mass screening for case finding.
2. Education of diabetic patients.
3. Education of the public.
4. Cooperation in education of physicians, nurses, dietitians and technicians.
5. Distribution of insulin to indigent diabetics.

It was stressed that no treatment of diabetic patients is to be done and that the program is not to be carried out in any area unless the county medical society concerned requests the State Board of Health to furnish these services, except in the case of distributing insulin which is required by law.

Your committee recommends that the Florida Medical Association approve the program of the State Board of Health Division of Diabetes Control as outlined in this report.

Respectfully submitted,
E. B. Hardee, *Chairman*

Report of Reference Committee No. 2

Dr. William M. Rowlett, chairman of Reference Committee No. 2, Public Policy, was recognized and asked to present the recommendations of that committee.

Dr. Rowlett: "Reference Committee No. 2 on Public Policy first considered the report of the Committee on Conservation of Vision."

Dr. Rowlett: "Your committee approves the report and recommends that the Committee on Conservation of Vision work for a plan for a standard or a uniform price to be charged for lenses and frames according to the grade sold."

Dr. Rowlett: "I move adoption of this report with recommendations."

Seconded by Dr. Hibbs. Motion carried.

Report of Committee on Conservation of Vision

Joseph W. Taylor, *Chairman*

Under the heading of Conservation of Vision, it is the opinion of your Chairman that spectacles should be one item of importance. Perhaps this matter should be handled by the Economics Committee; however I do not think a word here is out of place.

Perhaps the best argument to be raised against the medical profession in favor of socialized medicine is the high cost of spectacles, and that under the socialized plan the spectacles can be had free; not one pair but two.

Several years ago there was an editorial in the Florida State Medical Journal entitled "Spectacles for the Poor" where it was pointed out that people in the lower income bracket found it necessary to go to the dime stores to get cheap magnifying glasses in order to read the newspapers and do other close work. Since that time the cost of eye examination and glasses has greatly increased. When the wholesale optical companies were dispensing it was possible to get glasses for poor individuals at a greatly reduced rate. This is no longer possible with multiple opticians springing up like mushrooms, all trying to make a living, and, without any restrictions as to qualification or responsibility, the cost continues to mount. I would suggest the following recommendations.

First. That an optician be required to pass a board showing his qualifications and responsibility. I think this is very important as there is no other merchandise sold where it is so easy to cheat the customer as in the optical field. The average patient cannot tell the difference between first quality and inferior grades.

Second. That a standard or uniform price be charged for lens and frames according to the grade sold. The cost between the charge made by the wholesaler and the optician, who only spends a few minutes fitting a frame or selling fancy high-priced merchandise, is too great. Often his cut amounts to more than the wholesale price of the glasses plus the ophthalmologist's fee for examination.

Due to the prohibitive cost of spectacles many a child with an accommodative squint becomes amblyopic in one eye because the parents cannot afford the cost of glasses. The Lions Club is doing a great work in furnishing glasses to the poor but they cannot take care of all cases. In most communities the Kiwanis and other civic clubs are helping. The Council for the Blind will not furnish glasses unless the patient has been operated on for some eye trouble. I think this is a mistake as they pay the ophthalmologist a fee to examine these school children and older patients and if they need glasses the only way they can get them is through one of the civic clubs. If the Council cannot arrange some way to take care of the prescription for glasses, I do not see the advisability of spending the money for the examinations.

The optometrists are examining school children in many of the public schools and these examinations should be made by ophthalmologists. I quote the following from an article which appeared in the local papers during a recent meeting of optometrists.

Dr. William McClaflin, of Miami, reading diagnostician of the Dade County Schools, will present the school's approach to the reading problem in school children. He will also present new development in the correction of reading habits developed by the University of Miami Guidance center.

It must be borne in mind that almost one hundred per cent of the people must wear glasses some time during their life, provided they live to the presbyopic age and it is up to us as ophthalmologists to take care of not only patients of the presbyopic age, but pre-school and school children as well.

Respectfully submitted,
Joseph W. Taylor, *Chairman*

Dr. Rowlett: "Your committee approves the report of the Committee on Legislation and Public Policy and recommends that it become the policy of our Association for its president to call a joint meeting of the Board of Governors, Members of the House of Delegates, Bureau of Public Relations, and the Committee on Legislation and Public Policy, sixty (60) days before the convening of the Legislature for the purpose of planning a definite legislative program."

Dr. Rowlett: "Mr. Chairman, I move adoption of this report with recommendations."

Seconded by Dr. Herz. Motion carried.

Report of Committee on Legislation and Public Policy

Eugene G. Peek, *Chairman*

The chief activities of your committee were in connection with the 1949 Session of the Florida State Legislature. One member of your committee was on duty in Tallahassee during the entire session. This task was performed by your president, Dr. Payne, at the beginning of the session who stayed on the job until I was able to be present.

Dr. Payne and I were assisted by Mr. Gibson of the Bureau of Public Relations staff and, in compliance with an action of the 1948 House of Delegates, by the law firm of Messer and Willis, Tallahassee. Under mutual agreement, this law firm also represented Blue Shield, Blue Cross and the Florida Hospital Association.

All bills introduced into both Houses were checked, committee meetings were attended when pertinent bills were being considered, contacts were made with the legislators and we endeavored to serve as an intermediary between the legislators and their home doctors.

A detailed report of these activities was published in the November, 1949, issue of your Journal.

Your committee is of the opinion that much was accomplished of an indirect and intangible nature. The legislators learned that their doctors are interested in public health and medical legislation and that there is an organization set up for reporting their activities back to their home doctors.

On the tangible side we must acknowledge accomplishing little noteworthy of mention. Your committee believes that this can be explained in part by lack of sufficient preparation during the period intervening between sessions of the legislature; to the lack of a definite program to present to the legislators; and, of course, to the strength of the opposition when controversial measures were being considered.

Your committee believes that the experiences gained in the 1949 legislature clearly point the way for future actions. We must now get ready for 1951. The State Association must have a definite legislative program which can be submitted to the County Medical Societies in order that they may advise their members how to approach intelligently, as individuals, their representatives and senator. For most effective action this should be done before the primaries.

Doctors in those counties from which will come the President of the Senate and the Speaker of the House for 1951 have an especially important job cut out for them.

Your committee wishes to acknowledge that such constructive work as may have been accomplished would have been impossible without the considerable preliminary work done by the Bureau of Public Relations. Through them we were provided with the names of the members of the legislative committees in each of the County Medical Societies. We had at our disposal a cumulative file on each representative and senator and agreements had been worked out with the legal counsel provided for our use.

Your committee desires to express appreciation for the assistance given by the president, secretary, managing director, and other officers of the State Association; to the officers and members of the legislative committees of the County Medical Societies; to many individual doctors and particularly to Dr. Wilson T. Sowder, State Health Officer, and to Mr. Marshall H. Doss, Director, Bureau of Narcotics, Florida State Board of Health.

Respectfully submitted,
Eugene G. Peek, *Chairman*

Dr. Rowlett: "Reference Committee No. 2 approves the report of the Committee on Medical Education and Hospitals, with the deletion (on pages 20 and 21 of the Handbook) in Section I of paragraphs 2, 3 and 4, dealing with the location of the proposed State Medical College, as this would bring into action again a bitter sectional political fight."

Dr. Rowlett: "I move the adoption of this report as amended."

Seconded by Dr. Hibbs. Motion carried.

Report of Committee on Medical Education and Hospitals

Bascom H. Palmer, *Chairman*

I. MEDICAL EDUCATION

In the very important matter of Medical Education, it is observed that there has been achieved but little, if any, advancement of the facilities in our State for the formal teaching of the Medical Arts and Sciences on an accredited basis. To be sure, there are some worthy but small and inadequate efforts being made in the field of postgraduate Seminars which should be encouraged and supported. Residents training in the accredited hospitals is improving.

II. HOSPITALS

Your committee is pleased to observe that throughout the State there has been a great stimulus to the creation of new hospitals and expanding and improvement of the existing ones.

In addition to the several private hospitals that have been constructed, it appears to your committee that The Hospital Planning Division (Robert G. Carter, Supervisor) of the Florida State Improvement Commission is accomplishing an excellent undertaking in the allocation of Federal funds to the several counties of the State, grouped into classifications dependent upon tax supporting capacity of the county in relation to population. In other words, the less prosperous and least populated counties receive a larger percentage of grant monies. That formula would seem to be an equitable procedure.

Acting under the provision of this Hill Burton act, a five year program was undertaken and it is contemplated that in another three years when the program is com-

pleted there will have been added 2,465 additional general hospital beds and 874 specialized hospital beds. The total amount of the grant funds through June, 1955, is \$14,475,640.00. Thus, from this brief summary, it is easily seen that hospital facilities in the State are becoming greater.

III. NATIONAL EMERGENCY MEDICAL SERVICE

As to the special assignment for report on "National Emergency Medical Service" this committee has no report or recommendations as any local programs must be integrated with a National program which as yet has not been forthcoming.

IV. RURAL MEDICAL SERVICE

As to the special assignment for report on Rural Medical Service, this committee has no report at this time as the committee on Rural Health of the American Medical Association will not meet in Kansas City, Missouri, until February 3-4, 1950. It might, however, be stated as a belief that Florida has no serious rural health problem as there are practically no remote communities without accessible good roads, and even if the inhabitants did not possess automobile transportation to the larger communities, the Doctors in those communities certainly are able to render necessary professional attention.

This report has been unanimously approved by all members of this committee.

Respectfully submitted,
Bascom H. Palmer, *Chairman*

Dr. Rowlett: "Reference Committee No. 2 approves the report of Committee on Public Relations and also report of Sub-Committee to Public Relations Committee on State Education Campaign."

The reports, as approved, follow:

Report of Committee on Public Relations

Jos. S. Stewart, *Chairman*

Except for routine activities the Committee on Public Relations has spent its major effort on the campaign against Compulsory Health Insurance. A separate report on the Campaign of Education is shown below and in that report will be found the workings of the Committee on Public Relations.

Respectfully submitted,
Jos. S. Stewart, *Chairman*

Sub-Committee to Public Relations Committee on State Education Campaign

Jos. S. Stewart, *Chairman*

The work of this committee began in February, 1949, in Chicago when the American Medical Association called a meeting of its, "Committee of Fifty-Three." This committee was composed of one representative from each state and each territorial society. At this meeting the American Medical Association briefed the members on the overall plan of the Campaign for Education in regard to medical matters and medical care. Whitaker and Baxter were introduced and laid down their principles and a blue print of their plans.

On March 13th in Jacksonville your committee called a meeting of the Chairmen of the Public Relations Committees of the various county medical societies. The meeting was well attended and in many cases not only the president of the society but various members of the societies and members of the auxiliary attended. At this meeting the general policies as laid down by the American Medical Association were given to the county societies and everyone was briefed as far as possible on the overall state plan of the coming campaign.

Mr. H. A. Schroder of Blue Cross and Blue Shield of Florida was kind enough to loan to the Florida Medical Association Mr. John C. Lee who worked as Field Representative for the Bureau of Public Relations and the Committee on Education from March through June. Mr. Lee did an excellent piece of work for us and it is through his efforts that the Campaign of Education was started throughout the state. Mr. Ernest Gibson spent a great deal of time during the Legislature in Tallahassee and thus did not have extra time to devote to the work of this committee and this campaign. In October Mr. Harold Parham replaced Mr. Gibson as supervisor of the Bureau of Public Relations and Mr. Gibson became Assistant Managing Director of the Association.

Most of the county medical societies have done an excellent job in this campaign. Many resolutions from professional and lay organizations have been obtained and many thousands of people have been taught what the aims of medicine are and what the dangers of Compulsory Health Insurance mean. Even better work is expected during the coming year.

During February, 1950, the American Medical Association is having another meeting of its Committee of Fifty-Three in Chicago. The Chairman of this Campaign Committee as well as your President, Dr. Payne, and your Secretary, Dr. McIver, will attend. Mr. Parham will also be with us. At this meeting plans will be outlined for the future Campaign of Education.

Respectfully submitted,
Jos. S. Stewart, *Chairman*

Dr. Rowlett: "We approve the report of the Committee on State Controlled Medical Institutions."

Dr. Rowlett: "I move the adoption of this report."

Seconded by Dr. Stewart. Motion carried.

Report of Committee on State Controlled Medical Institutions

J. G. Lyerly, *Chairman*

Your committee on The State Controlled Institutions wishes to report on the Florida State Hospitals at Chattahoochee and Arcadia, and The Florida Farm Colony at Gainesville, Florida. These institutions are primarily for the treatment of the sick. There are other State Institutions which deal with problems other than sickness.

A better knowledge was obtained of The Florida State Hospital at Chattahoochee since monthly visits were made there during the past year. Dr. J. H. Therrel, Superintendent of the State Hospital at Chattahoochee gave some statistics as of the end of the year 1949. There were 5,584 patients confined to the State Hospital at Chattahoochee on that date. During the calendar year 1,616 patients were admitted, and 1,353 patients were released. There were 11 members of the medical staff attending these patients and there is a great need for more physicians at this institution. Dr. Therrel stated that additional funds have been made available by the last Legislature which will help to relieve the shortage of doctors, during the coming year. In this Institution there is an approved School of Nursing Education, and an Affiliate School of Psychiatric Nursing Education. There is also an approved Clinical Laboratory for the training of Medical Technicians. On the Medical Staff there are Visiting Consultants on general surgery, urology, neuro-surgery, and roentgenology. During the past year a new Infirmary building, consisting of 335 beds has been completed, and there is a Receiving and Psychiatric Treatment building of 200 beds which will be completed during this year.

In the Arcadia Branch of the State Hospital there were 887 patients with three physicians, and the allied medical personnel for the care of chronically ill patients transferred from Chattahoochee.

A communication has been received from Mr. R. C. Phillips, Superintendent, and Dr. A. D. Jordan, Medical Director of the Florida Farm Colony at Gainesville, Florida, setting forth the needs of that institution. There is a great need for an additional hospital building, a modern operating room, and additional x-ray facilities. There is a waiting list of 190 patients who have to wait a number of years for admission. No provision is made for the care of the colored patients, in this or any other institution of this kind in the State. This represents a definite need for correction in the future. A place should be provided for the care of certain cases of feeble minded children under six years of age. This is an age group that is not taken care of at the present time.

Respectfully submitted,
J. G. Lyerly, *Chairman*

Dr. Rowlett: "Your committee approves the report of Representatives to Industrial Council."

Dr. Rowlett: "I move adoption of this report."

Motion seconded by Dr. Hibbs and carried.

Report of Representatives to Industrial Council

G. Frederick Oetjen, *Chairman*

Our committee had a special assignment, INDUSTRIAL HEALTH, with a questionnaire entitled "Medical Relations in Workmen's Compensation—Policy of State Medical Associations."

This questionnaire was completed except for some questions that did not pertain here, as the commission has no medical staff, and forwarded to Dr. Sappington, Executive Officer, Committee on Workmen's Compensation, Council on Industrial Health, A.M.A. Dr. Sappington was also furnished a copy of the Florida State Workmen's Compensation Law and the fee schedule. There were no other activities of the committee during the year.

Respectfully submitted,
G. Frederick Oetjen, *Chairman*

Dr. Rowlett: "Reference Committee No. 2 approves NOT the resolution from the Marion County Medical Society to have the Florida State Motor Vehicle Bureau to substitute 'M.D.' instead of the letters 'DW' now used to designate the weight of the doctors' automobiles. We feel that such an act would be discriminatory and if adopted would be requested by allied professions and others. Doctors of medicine need no advertising."

Dr. Rowlett: "Mr. President, I move the resolution be NOT approved."

Seconded by Dr. Webster Merritt. Motion carried.

Dr. Rowlett: "Reference Committee No. 2 approves the resolution from the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, and recommends that in the third paragraph, second line, the words 'no doctor' be changed to read 'no member of the Florida Medical Association appear before any legislative com-

mittee without being properly briefed concerning the bill, and that he be designated to attend all committee hearings on such bills'."

Dr. Rowlett: "I move adoption of this resolution as amended."

Seconded by Dr. Herz.

Dr. Franz Stewart: "Perhaps I misunderstood the intent of the motion but as I understand it, it would restrict the right of a citizen of the State of Florida in appearing before his Legislature as a citizen. I feel that our citizenship stands before our profession."

Dr. Bates: "Will you please have the resolution read in its whole content?"

Dr. McIver, secretary, read the resolution as printed in the Handbook.

Dr. Stewart offered a substitute motion that the resolution be referred to the Committee on Legislation and Public Policy for study and recommendations, and then referred to the Board of Governors for recommendation.

Dr. Borland seconded the substitute motion which was carried.

Resolution

WHEREAS, There have been on several occasions at each Legislative Session doctors from various sections of the state attending committee hearings and these men have been asked to give their ideas on a bill sponsored by the Florida Medical Association or opposed by Florida Medical Association, or they even have volunteered, and

WHEREAS, These same men did not know the entire parts of the bill nor its background and these men were embarrassed and embarrassed the Florida Medical Association by not being able to answer intelligently the questions of the opposition,

NOW THEREFORE BE IT RESOLVED, That the Florida Medical Association strongly recommend that no doctor appear before any Legislative Committee without being properly briefed concerning the bill, and

BE IT FURTHER RESOLVED, That some doctor be briefed in any controversial bill, and that he be designated to attend all committee hearings of such bills.

*Respectfully submitted,
Leon-Gadsden-Liberty-Wakulla-
Jefferson County Medical Society
J. Lloyd Massey, President
Edward C. Love, Jr., Secretary*

This resolution to be referred to the Committee on Legislation and Public Policy for study and recommendations and then referred by it to the Board of Governors for recommendations.

Dr. Rowlett: "On the report of the Committee on Medical Economics, the introductory paragraph, No. 1, is approved. The remainder of the report is not approved as it is covered by the Committee on Public Relations."

Dr. Rowlett: "Mr. President, I move that the report as amended be approved."

Seconded by Dr. Day. Motion carried.

Report of Committee on Medical Economics

Herbert W. Virgin, *Chairman*

By telephone communication, and by a meeting in Orlando, Florida this winter, my Committee on Medical Economics of the State Medical Society has adjusted its viewpoint, to what we may term a practical and hard-bitten outlook. In looking over the various committees, it is apparent that many of them overlap what might be the field of Medical Economics. Hence, we have avoided any discussion of fees, of the various agencies handling indigent cases, and the tax supported institutions handling nonindigent patients. The Committee is continuing its study.

Respectfully submitted,
Herbert W. Virgin, *Chairman*

Dr. Rowlett: "We have a resolution relative to the fact that any member of the Florida Medical Association who is aware of anyone practicing medicine and receiving a fee without being properly licensed, should notify immediately the State Association and the Association should notify the Board of Medical Examiners. We have amended that to add 'also to notify the State Board of Health.' The assistance of the State Board of Health is quite necessary so we have added 'notify also the State Board of Health.' It adds to the resolution that the above is not meant to apply to bona fide interns and residents. In addition, since at times the state institutions have difficulty in obtaining interns for state hospitals, the Committee thought it would be advisable to add 'or physicians employed in state institutions who are encouraged to get their licenses within two years' time'."

Dr. Rowlett: "I move that this resolution be adopted as amended."

Seconded by Dr. Cole. (See substitute motion)

Dr. Borland: "To whom will this apply? What is the intent of the measure?"

Dr. Rowlett: "It applies to anyone who is practicing medicine without a license."

Dr. Bartlett: "I notice that the committee wants to extend a time of two years for state institutions, but if this is done, it will also have to apply to private institutions. In our locality, we have some of these mutual benefit organizations which pay a very low rate for physicians and they bring them down as interns and they stay indefinitely, as residents, but they also practice outside the hospital. I think when you start extending time to interns and residents, you are leaving open loopholes which we are trying to close."

Dr. Johnson: "I read this resolution which was signed by many members of this Association.

I interpreted it to mean any doctor who is practicing medicine in the State of Florida, except those exceptions."

Dr. Cason: "I would like to make a substitute motion that this be referred to the Board of Governors and then again to the House of Delegates for reconsideration next year."

Seconded by Dr. Bartlett. Motion carried.

Resolution

WHEREAS, the State Board of Medical Examiners has the legal power to determine who shall practice medicine in Florida, and

WHEREAS, the recommendations of the Florida Medical Association carry great weight with the Board of Medical Examiners,

BE IT HEREBY RESOLVED that the Florida Medical Association, upon receipt of written notice from any member that a Doctor of Medicine not possessing a Florida license is receiving remuneration for his professional services from any source in the state, immediately notify the State Board of Medical Examiners and the State Board of Health in writing of such irregularity, and recommend to the Boards in the strongest possible language that such practices be immediately stopped.

The above is not meant to apply to bona fide interns and residents or physicians employed in state institutions who are encouraged to get their licenses within two years' time.

Nelson A. Murray

Shaler Richardson

David R. Murphey, Jr.

W. M. Rowlett

Edward Canipelli

J. N. Patterson

A. Z. Oberdorfer

S. M. Day

Nathan Weil, Jr.

P. A. Drohomer

E. F. McCall

J. V. Freeman

E. C. Watt

L. B. Provinksy

This resolution to be referred to the Board of Governors for study and recommendations for presentation to the House of Delegates in 1951.

Dr. Rowlett: "The resolution introduced from the Hillsborough County Medical Association which in substance is that the approval of expansion of the State Board of Health into fields not strictly preventive medicine be limited to the House of Delegates of the Florida Medical Association."

Dr. Rowlett: "I move that this resolution be adopted."

Seconded by Dr. Herz.

Dr. Bryans: "It has been the policy of the Board of Health ever since I have been on the Board to refer these matters pertaining to the practice of medicine to your State Association through committees and the Board of Governors, and speaking for Dr. Melver and myself, we are heartily in favor of that. We consider ourselves your representatives. Sometimes public health is not confined exclusively to communicable diseases. For one illustration, the program for diabetic control. The public health doctors do not intend to treat diabetics but it is like the mass

x-rays on tuberculosis. If you find diabetes early, the chances are about 99% of living a normal or nearly normal life. If you let it go along until the patient is brought into the hospital in a diabetic coma with extreme acidosis, the chances are slim. I want to make it clear that your Board of Health is heartily in favor of this resolution."

Motion carried.

The following resolution was presented by David R. Murphey, Jr., M.D., at the regular monthly meeting of the Hillsborough County Medical Association, Inc., on March 7, 1950:

Resolution

WHEREAS, the practice of medicine in the State of Florida, is a privilege granted individual physicians by the state through its licensing boards, and

WHEREAS, the invasion of the field of medicine by tax-supported agencies is an infringement on this privilege, and

WHEREAS, in the past few years the State Board of Health, with approval of the Board of Governors of the Florida Medical Association, has extended its activities into fields not strictly preventive medicine, and

WHEREAS, the House of Delegates of the Florida Medical Association is more representative of the medical profession at large,

NOW, BE IT THEREFORE RESOLVED that future approval for expansion of the State Board of Health into fields not strictly preventive medicine be limited to the House of Delegates of the Florida Medical Association, sitting in regular session, and be it further resolved that the request for any proposed expansion be sent to the various component County Medical Societies at least sixty days in advance of the next scheduled meeting of the House of Delegates.

Respectfully submitted,

H. G. Cole, *Secretary*

Hillsborough County Medical Assn.

Dr. Rowlett: "The resolution presented from DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society relative to the policy of the State Cancer Control Program has been withdrawn by the delegate who introduced it."

Dr. Rowlett: "You heard a resolution yesterday that the House of Delegates of the Florida Medical Association confirm the action of the American Medical Association House of Delegates regarding the affirmation of the principles of the so-called 'Hess report.'"

Dr. Rowlett: "Reference Committee No. 2 approves this resolution as read. I move its adoption."

Seconded by Dr. Leigh Robinson. Motion carried.

Resolution

WHEREAS, Chapter III, Article VI, Section 6, of the recently adopted revised Principles of Medical Ethics of the American Medical Association reads:

PURVEYAL OF MEDICAL SERVICE

Section 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever

name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

WHEREAS, The committee known as the "Hess" Committee reported to the American Medical Association House of Delegates in Atlantic City in June 1949, in detail, regarding the Practice of Medicine by Hospitals,

WHEREAS, The "Hess" report in one paragraph stated in explanation as follows: "Therefore, hospitals and medical schools cannot charge patients fees for medical services rendered by physicians even though the physicians are full time employees of an individual or institution,"

WHEREAS, The "Hess" report was adopted by the American Medical Association House of Delegates and the Trustees of the American Medical Association were instructed to enforce the principles and obligations involved,

WHEREAS, The House of Delegates of the American Medical Association in Washington in December 1949, reaffirmed its belief in and confirmed the principles stated in the "Hess" report and directed that action by the Trustees be deferred only until all legal requirements were met in order to insure that all action taken shall comply with the law,

WHEREAS, The Trustees of the American Medical Association are to report to the House of Delegates in June 1950, regarding this matter and the "Hess" Committee is to report its further study,

THEREFORE, BE IT RESOLVED, The House of Delegates of the Florida Medical Association confirms the action of the American Medical Association House of Delegates regarding the reaffirmation of the Principles of the so-called "Hess" report.

BE IT FURTHER RESOLVED, The House of Delegates of the Florida Medical Association requests the American Medical Association House of Delegates to expedite action and implement methods that WILL enforce the Section 6, Article VI, Chapter III of the Principles of Medical Ethics without delay.

BE IT FURTHER RESOLVED, Our Delegates to the American Medical Association are hereby instructed regarding these desires and requested to work for their fulfillment.

Dr. Rowlett: "I am calling on Dr. Langley to discuss the resolution presented by Dr. Roberts of the Bay County Medical Society relative to past presidents."

Dr. Langley: "The resolution as given to Reference Committee No. 2 proposes that all past presidents of our Association become ex officio delegates to our convention. The committee recommends the adoption of this resolution except that any county having more than three living past presidents, should include the other past presidents, above three, in its normal quota of delegates."

Dr. Joseph S. Stewart: "Does this House have the authority to tell the county societies whom they shall or shall not elect as delegates? I believe it is unconstitutional because it tells the county societies whom they shall have as a delegate."

By consent of the House the Chair recognized Dr. Herpel.

Dr. Herpel: "I have the feeling that in most cases the past presidents have established for themselves a place in their county and state associations. If they, as past presidents, are not sufficiently interested and active to justify themselves as delegates, I think it is a mistake to make them automatically members of the House of Delegates because they are past presidents."

Dr. Jelks: "In view of what has just been said, I am rather embarrassed to discuss this. I am appearing as a representative of the delegates of the Duval County Medical Society. Many of them discussed this yesterday. Our feeling is this: That it is an unfair arrangement and I am embarrassed again because if this went through as proposed, Duval County's representation would be twelve plus five instead of twelve. So far as members are concerned, I don't know what other men think about it, but, personally, I am sure the past presidents, and I have have the honor to be one of them and appreciate it as much as anything in my life, but I think we have shown our loyalty to this group. If anyone wants a past president to do anything, he will do it. They have the authority to get up at meetings without asking the privilege of the floor but at the same time, it is unfair to unbalance our method of representation of the men in the Association."

Dr. Bates: "I move that this resolution now before the House of Delegates be tabled."

Seconded by Dr. Carlton. Motion carried.

Reference Committee No. 3

Dr. Walter C. Jones: "We have some rather detailed matters to take up with the House of Delegates and I think it would be to your advantage to refer to your Handbook as we take up the various matters under discussion.

Dr. Jones: "On page 26, paragraph 5, under report of the Board of Governors, your committee recommends that the meeting schedule as set up by the Board of Governors for Reference Committees of the House of Delegates to meet during a scientific assembly be approved. I move its adoption."

Seconded by Dr. Bryans. Motion carried.

Dr. Jones: "On page 27, paragraph 2, your committee recommends that the Hollywood Beach Hotel in Hollywood be selected as the headquarters hotel for the Association's Seventy-Seventh Annual Convention."

Dr. Jones: "I move its adoption."

Seconded by Dr. Rowlett. Motion carried.

Dr. Jones: "On page 27, paragraph 3, and the bottom of page 30, your committee recommends the adoption of the resolution as it appears in the Handbook for Members of the House of Delegates, concerning members in military service."

Dr. Jones: "I move its adoption."

Seconded by Dr. Herz. Motion carried.

Resolution (paragraph 113): Be deleted and the following inserted in lieu thereof:

MILITARY SERVICE — DUES
(113)

RESOLUTION

Whereas, for several years the fighting war has been over; and

Whereas, few of our members are called into military service; and

Whereas, members who are in or enter military service by their own volition or request shall pay state dues,

Be It Therefore Resolved, that those members on active duty by their own volition or request shall pay state dues; that those men who are in military service not by their own volition or request will not be required to pay state dues.

Dr. Jones: "On page 29, paragraph 8 and page 30, paragraph 3, your committee recommends that the suggestion for changing the Constitution to provide for 'Associate Members' be deleted and given further study by the Board of Governors and that it be presented at a later date."

Dr. Jones: "I move the suggestion be approved as amended."

Seconded by Dr. Day. Motion carried.

Constitution, Article IV, Sec. 6, (paragraph 9): Associate Members — Doctors of medicine employed full-time by the Veterans Administration and Federal or State Agencies in Florida are eligible for this membership classification. Associate members will not be required to pay an entrance fee nor eligible to vote or hold office. They will be required to pay the usual annual dues for county and state associations. Component county medical societies are requested to change their Constitutions and By-Laws to conform with this procedure.

Constitution, Article IV, Sec. 1, (paragraph 4): In line 3, after "Honorary Members," insert "Associate Members." That "Sec. 6" be deleted and that "Sec. 7" be inserted in lieu thereof.

This suggested change in Constitution to be referred to the Board of Governors for further study and to be presented at a later date.

Dr. Jones: "On page 27, paragraph 4, and page 30, paragraph 2, your committee recommends approval of increase in State Association dues to \$40.00 (effective Jan. 1, 1951) and suggests that the secretary make any necessary explanations, if requested."

Dr. Jones: "I move its adoption."

Seconded by Dr. Jelks.

At this point, Dr. McIver left the rostrum to show slides.

Dr. McIver: "Yesterday, our president delivered his presidential address. I am sorry that one of the finest addresses delivered before this Association in many a day was attended by so few."

Dr. Payne: "I think it might be wise if the treasurer would explain just how our finances are coming out this year and the year before, and just what our finances are at the present time."

Dr. McIver read the first portion of the report of the Secretary-Treasurer and Managing Director.

Dr. Payne: "This motion is open for debate."

Dr. Sims: "I would like to put this thought before the House of Delegates; this will be hard on the rural areas and small societies."

Motion carried.

By-Law, Chapter VIII, Sec. 1, (paragraph 90): An assessment of \$40 per capita on the membership of the component societies is hereby made the annual dues of the Association. Included in this amount is a subscription for the Journal. Any new member accepted into the State Association shall be required to pay a \$10 entrance fee and the reinstatement entrance fee for a member who is reinstated after having been dropped from the roster shall be the same amount as the current annual dues in addition to his first year's dues. The secretary of each county medical society shall forward its assessment, together with its roster of all officers and members, and list of delegates of the society, to the secretary of this Association on or before February 1, basing the number of delegates on the membership at the end of the previous calendar year.

Dr. Jones: "On pages 27 and 28, report of Sub-Committee to the Board of Governors on Review of Fee Schedules, your committee, after careful consideration, and extensive discussion with members present, decided to disapprove the action, but at the same time thank this sub-committee for its efforts in putting forth the medical ideas expressed."

Dr. Jones: "I move this Sub-Committee report be disapproved and not published in The Journal and that it be referred back to the Board of Governors for disposal as it sees fit."

Seconded by Dr. Cole. Motion carried.

Dr. Jones: "On page 29, your committee recommends the adoption of the report of Sub-Committee to the Board of Governors on Veterans Care and that this sub-committee be commended for its action."

Dr. Jones: "I move its adoption."

Seconded by Dr. Rowlett. Motion carried.

Sub-Committee to Board of Governors on Veterans Care
Frederick H. Bowen, *Chairman*

I have written the two regional offices of the Veterans Administration for information concerning the veterans cared for in 1949.

The Miami Regional Office has advised that 276 members of the Florida Medical Association were paid for taking care of 10,065 veterans during 1949 in the amount of \$106,425.30

The Pass-A-Grille Regional Office has stated that during the same year, 386 physicians rendered medical care to 15,404 veterans at a cost of \$169,957.

The two Regional Office statements combined show totals as follows: physicians 662, veterans 25,469 and cost \$276,400.30.

Respectfully submitted,
Frederick H. Bowen, *Chairman*

Dr. Jones: "On page 31, the second resolution, your committee recommends the approval of the resolution on complaints occurring in the practice of medicine in hospitals with the exception that the following last words be omitted: 'to the Judicial Council of the American Medical Association'."

Dr. Jones: "I move its adoption as amended."

Seconded by Dr. Davis. Motion carried.

RESOLUTION

The Committee on Medical Education and Hospitals of the Florida Medical Association is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals, wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Medical Education and Hospitals, its findings to that effect shall be transmitted to the Board of Governors of the Florida Medical Association with its recommendations, in order that the Board of Governors may then make suitable recommendations.

Dr. Jones: "On page 31, first paragraph, your committee recommends that the word 'white' in paragraph 101 of the By-Laws, Chapter XI, Sec. 5, be deleted."

Dr. Jones: "I move that this change be made as recommended."

Seconded by Dr. Hibbs. Motion carried.

By-Law, Chapter XI, Sec. 5, (paragraph 101): In line 5 delete the word "white."

Dr. Jones: "I move that the Report of the Board of Governors be approved as amended."

Seconded by Dr. Herz. Motion carried.

Report of Board of Governors

Walter C. Payne, *Chairman*

Three meetings of the Board of Governors were held as follows: April 13, 1949, September 18, 1949, and January 22, 1950.

The dates for the Seventy-Sixth Annual Meeting of the Association at Hollywood were set for April 23-26, 1950.

An operating budget for the ensuing year was presented by Dr. Robert B. McIver, secretary and approved.

Dr. Eugene G. Peek, new chairman of the Association's Committee on Legislation and Public Policy assumed his responsibilities April 13, 1949. Since Dr. Peek had retired from active practice, he proposed to be in Tallahassee or available continuously. This service for medical information where senators, representatives and others could obtain answers to questions on medical and health bills served a real need. Your Board of Governors gave Dr. Peek full authority for the Florida Medical Association in legislative matters and that he had approval of the Board of Governors on any commitments that we have made or may make. This procedure was most satisfactory and prevented unnecessary confusion.

A schedule to be followed at the Seventy-Sixth Annual Meeting was discussed in detail and approved. Your printed program shows the schedules as designated. One innovation from last year's schedule was to have the first meeting of the House of Delegates on Tuesday morning and the meetings of the three Reference Committees at 2:30 p.m. Heretofore Reference Committees of the House of Delegates did not have sufficient time to hold hearings and prepare their recommendations for the second meeting of the House of Delegates. It is the opinion of your Board members that this change will be helpful.

The report of Drs. Louis M. Orr, II, and Homer L. Pearson, Jr., delegates to the A.M.A. House of Delegates in June, was read and published in the November Journal.

In order that the reports of the Association's delegates to the A.M.A. be available to the members without the delay of waiting for a meeting of the Board of Governors, your Board took action to have these reports mailed directly to the editor of The Journal for publication.

At the request of the Board, Dr. Homer L. Pearson, Jr., investigated the possibility of providing membership in the Association for Negro physicians. Dr. Pearson reported several times, submitted a letter from the A.M.A. and contacted a number of persons for information and their experiences.

After much deliberation, your Board took action to recommend to this meeting of the House of Delegates that the word "white" in By-Law Chapter XI, Sec. 5, (paragraph 101), line 5 be deleted.

An application was presented from Mr. Ernest R. Gibson to succeed Mr. Nelson P. Moyer as assistant managing director. Dr. McIver, secretary, was requested to notify Mr. Gibson that he would be put on as assistant and to explain what the position entailed.

President Payne and Secretary McIver were authorized to obtain the services of a man to supervise the Bureau of Public Relations. Mr. Wm. Harold Parham was selected and assumed his duties on October 18, 1949.

A survey of hotels was made in connection with the meeting place for the Seventy-Seventh Annual Meeting in 1951. The Hollywood Beach Hotel at present offers the best facilities for holding the Association's Annual Meeting. Your Board, therefore, recommends that the Hollywood Beach Hotel in Hollywood be designated as the meeting place for the 1951 Annual Meeting. The By-Laws provide that the dates for the meeting shall be set by the Board of Governors.

It is the consensus of the Board that the Resolution adopted by the House of Delegates and effective January 1, 1942 (paragraph 113) is obsolete owing to the fact that the fighting war has been over more than four years and that medical officers now in military service are well able to pay state dues. Your Board made a ruling, to be effective until this meeting of the House of Delegates, to the effect that members in military service shall no longer be excused from paying annual dues, with this exception—that those men who are in regular service, not by choice, shall have the right to go under the old resolution of not paying dues; those who are on active duty by their own volition or request must pay state dues.

Resolution (paragraph 113): Be deleted and the following inserted in lieu thereof:

**MILITARY SERVICE — DUES
(113)**

RESOLUTION

Whereas, for several years the fighting war has been over; and

Whereas, few of our members are called into military service; and

Whereas, members who are in or enter military service by their own volition or request shall pay state dues,

Be It Therefore Resolved, that those members on active duty by their own volition or request shall pay state dues; that those men who are in military service not by their own volition or request will not be required to pay state dues.

Owing to unusual activities of the Association which are increasing rapidly, there is not sufficient income to meet operating expenses. Your Board, therefore, recommends that the annual dues be increased from \$25.00 to \$40.00, effective January, 1951, and that the reinstatement entrance fee for a member who is reinstated after having been dropped from the roster shall be the same amount as the current dues.

By-Law, Chapter VIII, Sec. 1, (paragraph 90): An assessment of \$40 per capita on the membership of the component societies is hereby made the annual dues of the Association. Included in this amount is a subscription for the Journal. Any new member accepted into the State Association shall be required to pay a \$10 entrance fee and the reinstatement entrance fee for a member who is reinstated after having been dropped from the roster shall be the same amount as the current annual dues in addition to his first year's dues. The secretary of each county medical society shall forward its assessment, together with its roster of all officers and members, and list of delegates of the society, to the secretary of this Association on or before February 1, basing the number of delegates on the membership at the end of the previous calendar year.

On request by Dr. Colquitt Pearson, president, Florida Society of Anesthesiologists, this society was approved as a Specialty Group to meet with other authorized groups the day before the Association's Annual Meeting.

On recommendation of Dr. Jere W. Annis, secretary, Florida Heart Association, this association was authorized to meet the day before the Association's Annual Meeting in like manner as other Specialty Groups with the exception that their meeting shall be confined to members of the Florida Medical Association.

The number of Specialty Groups now authorized to meet the day preceding the Association's Annual Convention is eighteen. Names of the specialty societies and their presidents and secretaries appear in the back of your Journal each month.

The report of the Sub-Committee to the Board of Governors on Review of Fee Schedules was presented by Dr. Chas. J. Collins, chairman. Your Board accepted with thanks the Sub-Committee's Report on Review of Fee Schedules without recommendation.

House of Delegates disapproved this report and referred it back to the Board of Governors for disposal as it sees fit (not to be published in this Journal).

The following report from Dr. Frederick H. Bowen, chairman of Sub-Committee to Board of Governors on Veterans Care was received and accepted.

Sub-Committee to Board of Governors on Veterans Care

Frederick H. Bowen, *Chairman*

I have written the two regional offices of the Veterans Administration for information concerning the veterans cared for in 1949.

The Miami Regional Office has advised that 276 members of the Florida Medical Association were paid for taking care of 10,065 veterans during 1949 in the amount of \$106,425.30.

The Pass-A-Grille Regional Office has stated that during the same year, 386 physicians rendered medical care of 15,404 veterans at a cost of \$169,957.

The two Regional Office statements combined show totals as follows: physicians 662, veterans 25,469 and cost \$276,400.30.

Respectfully submitted,
Frederick H. Bowen, *Chairman*

**Sub-Committee to Board of Governors on
Liaison—National Foundation Infantile Paralysis**

Frederick H. Bowen, *Chairman*

There is no report from this sub-committee dealing with the Foundation for Infantile Paralysis for this year.

Respectfully submitted,
Frederick H. Bowen, *Chairman*

Dr. Joseph S. Stewart, Chairman of the Association's Committee on Public Relations, was authorized to sponsor a state-wide essay contest for students of junior and senior high schools on "Why The Private Practice of Medicine Furnishes This Country With The Finest Medical Care" and that three prizes be given as follows: first prize, \$100.00; second prize, \$50.00; third prize, \$25.00.

Paragraph on Associate Members, Constitution Article IV, Sec. 6, to be referred to the Board of Governors for further study and to be presented at a later date.

Your Board recommends adoption of a resolution which reads in part: "The Committee on Medical Education and Hospitals is specifically charged with the responsibility of receiving and considering all complaints, etc." (Note complete resolution under recapitulation at the end of this report.)

RESOLUTION

The Committee on Medical Education and Hospitals of the Florida Medical Association is specifically charged with the responsibility of receiving and considering all complaints and or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals, wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Medical Education and Hospitals, its findings to that effect shall be transmitted to the Board of Governors of the Florida Medical Association with its recommendations, in order that the Board of Governors may then make suitable recommendations.

The following doctors on recommendations of their local county medical societies were elected to honorary membership: Drs. Milton B. Kay, Robert J. Poppiti, J. Dever Stuart, Claude C. Pearce, Anna A. Darrow, Robert Blessing, James I. Thorne, E. Borland Gill.

Respectfully submitted,
Walter C. Payne, *Chairman*
Board of Governors

Dr. Jones: "Regarding the resolution from the Brevard County Medical Society relative to fees for expert medical testimony, your committee feels that probably the Brevard County Medical Society is not thoroughly informed and the committee is satisfied that the law is not as stated, and recommends that no action be taken."

Dr. Jones: "I move that no action be taken and resolution not be published in The Journal."

Seconded by Dr. Davis. Motion carried!

Dr. Jones: "On page 35, see resolution for the creation of a State Grievance Committee."

Dr. Jones: "I move that this resolution be adopted."

Seconded by Dr. Roberts. Motion carried.

Resolution

Grievance Committee—State

WHEREAS, There is recognized the necessity for a medium through which patients may voice real or imagined grievance against the medical profession, and cognizance is taken of the advisability of a committee to which such complaints may be presented; and

WHEREAS, The experiences of other state medical associations which have provided such committees have indicated them to be satisfactory and efficacious; and

WHEREAS, The House of Delegates of the American Medical Association has approved a resolution urging the establishment of such grievance committees in all state medical associations; therefore be it

RESOLVED, That this House of Delegates hereby authorize the establishment of a grievance committee to hear and weigh complaints from the public relative to the profession and medical practices; and that this committee be composed of the five immediate past living presidents of the Florida Medical Association; and be it

RESOLVED, That the said committee be empowered immediately to make such surveys of the experiences of other state medical associations as it deems essential and to draft rules and regulations to govern the activities of said committee, consistent with the policies of the Florida Medical Association; and be it further.

RESOLVED, That funds for necessary operating expenses be subject to the approval of the Board of Governors of the Florida Medical Association; and that an annual report be made to the House of Delegates in the same manner as regular standing committees.

W. C. Payne, *Delegate*

Dr. Jones: "On page 35, see resolution for the creation of a County Mediation Board."

Dr. Jones: "I move that this resolution be adopted."

Seconded by Dr. Roberts. Motion carried.

Resolution

Mediation Board—County

WHEREAS, It is recognized that misunderstandings will, in instances, arise between physician and patient; and

WHEREAS, It is accepted that it is to the interest of the profession and the public to have these differences settled as quickly as possible in a just and amicable manner; and

WHEREAS, It is believed that the logical unit to resolve such problems with diplomacy and dispatch is the local medical society; and

WHEREAS, It is anticipated that a Grievance Committee will be established on the state level to which complaints may be referred, either directly or in appellation; therefore be it

RESOLVED, That each county medical society be urged to establish a mediation board, or similar committee by whatever name, to enable any person to present his grievances in a rational and dignified manner; and be it further

RESOLVED, That, in order to avoid possible contradictions in policies and procedures, the county medical societies be requested to pattern their mediation boards as nearly as practicable after that of the state grievance committee.

W. C. Payne, *Delegate*

Dr. Jones: "On page 32, see report of the Committee on Interrelationship. This is approved

with the following amendment: That the figure '\$1,000.00' be deleted and the figure '\$500.00' be inserted with the recommendation that the request be met if the money is available."

Dr. Jones: "I move the adoption of this report as amended."

Seconded by Dr. Cason. Motion carried.

Dr. Jones: "On Resolution No. 1, see action on committee report."

Dr. Jones: "On Resolution No. 2 relative to physician-owned pharmacies, the committee recommends that no action be taken."

Dr. Jones: "I move that no action be taken on this resolution."

Seconded by Dr. Stebbins. Motion carried.

Dr. Jones: "On Resolution No. 3, which relates to the practice of some physicians in the state charging patients for biologicals furnished free by the State Board of Health, your committee recommends that this resolution be approved."

Dr. Jones: "I move that this be approved as read."

Seconded by Dr. Bartlett. Motion carried.

Report of Committee on Interrelationship

Henry J. Peavy, *Chairman*

Your Committee has kept in touch with the Bureau of Professional Relations of the School of Pharmacy of the University of Florida. Dr. P. A. Foote, Director of the Bureau, continues to do an outstanding job with more accomplished, on less funds.

The Bureau presented two educational exhibits; one before the 1949 Convention of the Florida Medical Association, and one at the Seventeenth Annual Graduate Short Course.

A new edition of the Florida Formulary is contemplated in 1950.

A Symposium on Interprofessional Relations was presented before the Convention of the American Pharmaceutical Association, which was held in Jacksonville, in April, 1949. Dr. P. A. Foote presided. Dr. Claude L. Carter of Jacksonville, gave the viewpoint of the physician, while Mr. Don S. Evans of Orlando, spoke on the pharmacists' point of view.

The Decennial Pharmacopeial Convention, will be held in May in Washington, D. C., for the purpose of electing a U. S. P. Revision Committee for 1950-60. The Florida Medical Association is entitled to send three delegates. Inasmuch as Dr. P. A. Foote is now a member of the present Revision Committee, President Payne has accepted his offer to find some interested pharmacists to represent the Florida Medical Association, if none of the F. M. A. members wish to go. However, it is hoped that one or more physicians can attend this Convention.

The Bureau of Professional Relations is completing a decade of service. It is sponsored by the Florida Medical Association, but is financially supported by the Florida State Board of Pharmacy, and the University of Florida, College of Pharmacy. Since it was organized in 1940, the Florida State Board of Pharmacy has contributed for its operation, \$42,100.00. In recent years the University of Florida has added \$10,600.00. Since the Florida Medical Association has sponsored, but not contributed to its support, your Committee recommends that a sum of money, not exceeding \$500.00, be appropriated each year to the support of the Bureau of Professional Relations.

Supplement

After the Handbook deadline, this committee had several matters referred to it by President Walter C. Payne and they are offered for your consideration in the following resolutions:

Resolution 1. The Florida Medical Association has sponsored but not contributed financially to support of the Bureau of Professional Relations.

Funds have been curtailed and the Bureau of Professional Relations needs help to carry on and to revise the accepted Florida formulary; therefore,

BE IT RESOLVED, that the Florida Medical Association subscribe \$500.00 annually to support of the Bureau of Professional Relations, University of Florida, if the money is available.

Resolution 3. BE IT RESOLVED that the Florida Medical Association disapprove the practice of some physicians in the state who have been charging patients for biologicals furnished free by the State Board of Health.

BE IT THEREFORE RESOLVED that continuation of such a practice be reported by local health officers to local county associations for investigation and correction.

Respectfully submitted,
Henry J. Peavy, *Chairman*

Dr. Jones: "On page 34, see a resolution by the Leon - Gadsden - Liberty - Wakulla - Jefferson County Medical Society on changing the date of the Association's Annual Meeting. Your committee recommends that this be referred to the Board of Governors and any necessary recommendations be made at a future date."

Dr. Jones: "I move that this resolution be referred to the Board of Governors."

Seconded by Dr. Herz. Motion carried.

Resolution

WHEREAS, The State Legislature convenes every two years at the time that our State Legislation and Public Policy Committee appointments are made, which disrupts the committee's program, interferes with co-ordination and jeopardizes its effectiveness with lack of full co-operation,

THEREFORE BE IT RESOLVED, That the Florida Medical Association take necessary steps to remedy this situation either by changing the time of the Committee appointments or the meeting of the Association.

Respectfully submitted,
Leon-Gadsden-Liberty-Wakulla
Jefferson County Medical Society
J. Lloyd Massey, *President*
Edward C. Love, Jr., *Secretary*

Dr. Jones read the report of the Committee on Necrology and the supplemental report and moved that they be approved.

Seconded and carried.

Report of Committee on Necrology

Joseph Halton, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Nelson M. Black, Jr., Miami
John T. Bradshaw, San Antonio
Joseph R. Carver, Branford
William T. Elmore, Gainesville
Chas. K. Farber, St. Petersburg
Frederick L. Flynn, St. Petersburg
Spencer A. Folsom, Orlando

Harry Hausman, Daytona Beach
Luther A. Hodsdon, Miami
Waldo Horton, Winter Haven
Rayburn N. Joyner, Marianna
E. Thomas Kinsey, Madison
Young C. Lott, Miami
Louis R. Marshall, Jacksonville
Robert H. McGinnis, Jacksonville
Thomas A. Neal, Orlando
Karl W. Ney, Stuart
Leon H. O'Quinn, Hialeah
Julius A. Oshlag, Miami Beach
C. Larimore Perry, Miami
Nilo C. Pintado, Miami
Thomas R. Purcell, Clearwater
Harold F. Preston, Melrose
Robert E. Repass, Miami
Ernst P. E. Sengstak, Daytona Beach
Juan Silverio, Miami
Thomas K. Slaughter, Wildwood
Sheldon Stringer, Brooksville
Raleigh R. Sullivan, Lakeland
Major E. Threlkeld, Miami
John A. Toomey, Cleveland, Ohio
William H. Watters, Miami
Robert C. Woodard, Miami

Supplement

William D. Brinson, Baldwin
James L. Chalker, Ocala
John E. Hall, Miami
John A. Hardenbergh, St. Petersburg
Elliott M. Hendricks, Ft. Lauderdale

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Joseph Halton, *Chairman*

Dr. Jones: "In reverence to our departed colleagues and out of respect to their memory, may we stand for a moment of silence."

Dr. Jones: "On page 33, the report of the Committee on Advisory to Woman's Auxiliary, your committee recommends that this report be adopted."

Dr. Jones: "I move that this report be adopted."

Seconded by Dr. Cole. Motion carried.

Report of Committee on Advisory to Woman's Auxiliary

Edward F. Shaver, *Chairman*

As Chairman of the Committee on Advisory to the Woman's Auxiliary, I wish to report that we advised the Auxiliary that the program urged by National Education Campaign Committee, to center its activities for the year, and their programs in particular, around the Twelve Point Program of the American Medical Association for the Advancement of Medicine and Public Health, met with our approval.

We also approved the program for "Florida Health Week" believing it would afford us an opportunity to enlighten the public against Compulsory Health Insurance, and at the same time making them more Health Conscious.

Respectfully submitted,
Edward F. Shaver, *Chairman*

Dr. Jones: "On page 33, the Report of Council, we have approved this report and recommend that new charters be issued to two component county medical societies to be designated as follows: "Lee-Charlotte-Collier-Hendry County Medical Society and DeSoto-Hardee-Highlands-Glades County Medical Society."

Dr. Jones: "I move that this report be adopted."

Seconded by Dr. Leigh Robinson. Motion carried.

Report of Council

Russell B. Carson, *Chairman*

An application has been received requesting charters for two county medical societies as follows: DeSoto-Hardee-Highlands-Glades County Medical Society and Lee-Charlotte-Collier-Hendry County Medical Society.

After several months' correspondence with the secretaries of these two county medical societies, the Council has approved the change in names and recommends that charters be issued accordingly.

Collier and Hendry Counties have not heretofore been officially recognized in a county society name. Charlotte County is shown with DeSoto-Hardee-Highlands-Glades County Medical Society but by mutual agreement "Charlotte" should be deleted and shown with the Lee County group.

During the past year the Council has received neither complaints nor grievances from either individual members of the Florida Medical Association or County units. The principal activities of the Council concerned the arrangement of the District Meetings which were held during the week of October 24-28.

With the excellent cooperation of the members of the Council a program was outlined for the District Meetings which met with unusual success. The officers of the Florida Medical Association gathered in Quincy on October 24 for the first of the series of meetings at the Sawano Country Club. On October 26 they met at the Elks Club in Palatka, the Sebring Hotel in Sebring on October 27 and the Tradewinds Hotel in Fort Lauderdale on October 28. The quality of the scientific program was especially good and was enthusiastically received by the audience of each meeting. The following list of papers and authors was presented:

Quincy

Multiple Small Bowel Intussusception — Nathan Arenson, Pensacola

Address (by invitation), Consideration of the Pancreas in the Diagnosis of Upper Abdominal Diseases — Edwin H. Andrews, Gainesville

Palatka

The Nonfunctioning Gallbladder — Alphonsus M. McCarthy, Daytona Beach

A general Practitioner's Care of the Prostate — A. Fred Turner, Jr., Orlando

Sebring

Jaundice — Joseph C. Flynn, Tampa

Address (by invitation), The Toxic Effect of Tetraethylpyrophosphate (T.E.P.P.) — Garland M. Johnson, Fort Lauderdale

Fort Lauderdale

The Pathology of the Female Urethra, A Review — Milton M. Coplan, Miami

Address (by invitation), Observations on Digitoxin — Henry Fuller, Lakeland

Reports were made by the officers of the Association and discussion of the policies and problems of the Association was carried on at each meeting.

Your Chairman has attended District Meetings for a number of years and has felt that they have progressively improved and are taking their place as an important and essential part of the activities of the Florida Medical

Association. I would, however, like to make a recommendation that more publicity be given to the meetings, in order to obtain larger attendance and that the Woman's Auxiliary of each County Medical Society be urged to hold parallel meetings at the time of the District Meetings.

Recommendation for Action

That new charters be issued to two component county medical societies to be designated as follows:

Lee-Charlotte-Collier-Hendry County Medical Society
DeSoto-Hardee-Highlands-Glades County Medical Society

Respectfully submitted,
Russell B. Carson, *Chairman*

Dr. Payne: "The Chair wishes to express appreciation to Drs. Jones, Rowlett and Annis and the members of their committees for their very fine work. It is my belief that the business of the House was better attended to than in any previous meeting. I would like to express the appreciation of the Chair for the very courteous attention and the businesslike manner in which the delegates disposed of the business of the Association."

The Chair recognized Dr. Homer Pearson.

Dr. Payne: "It is four minutes until twelve. We will recess until 12:00 o'clock."

Dr. Payne: "It is now 12:00 and as required by our Constitution, it is now time for the election of officers for the coming year. The first is that of president-elect."

The Chair recognized Dr. William M. Davis of the Pinellas County Medical Society.

Dr. Davis: "I count it a privilege and a pleasure to place in nomination the name of a man who, I feel sure, will make a worthy successor to the long line of distinguished past presidents of this Association. He is held in high esteem by his fellow practitioners; he is a man of industry and high ethical standards; he is young enough to be enthusiastic and energetic, but old enough to be of mature judgment. He has been president of his county medical society; he is active in the work of the Association, having been a member of the Board of Governors for the past two years, and he is now our first vice president.

"He was born in Anniston, Alabama, received his A.B. from the University of Alabama, his M.D. from Vanderbilt University in 1930. He received the degree of Master of Surgery from the University of Virginia. He settled in Tampa in 1935 where he has remained in practice except while with the Armed Services from 1942 to 1946.

"I think you will agree with me that in the present troublous times organized medicine needs able leadership, which I believe my nominee can

give. I could spend much more time telling you of the desirable qualifications of this man, but I believe I have said enough to convince you that he would make an ideal president. I nominate Dr. David R. Murphey, Jr., of Tampa."

Dr. Payne: "Dr. David R. Murphey, Jr. of Tampa has been nominated."

Dr. Roberts: "I personally stand for Dave Murphey. I have had the pleasure of sitting by him in numerous classrooms at the University of Alabama, and if it hadn't been for Dave, I doubt if I would have been a doctor. I could talk and talk about his virtues; it would take too much time, but I can tell you very briefly about his shortcomings—he has none. I, too, endorse David R. Murphey, Jr."

Dr. Rowlett: "My fellow society members, I am pleased with this nomination and would like to add a few words. In addition to the accomplishments that Dave Murphey has made for the State Association, I have known him for 15 or 16 years, but he has accomplished more in organized medicine in that length of time than many who have been here twice that length of time. He has occupied every position of honor in the Hillsborough County Medical Association, and in addition to his excellent work in organized medicine, he has led an outstanding fight against communism and socialized medicine."

"I would like to repeat one little incident of a few days ago. He was invited to address the Association of Beauticians. They told him that he could not talk on politics and they presented to him the topic of 'Cancer'. The speech that Dave Murphey made before that body on 'Cancer of Socialism', I wish every member of the House of Delegates had heard. In fact, they became so thrilled, they forgot all about politics."

"Now, yesterday, I entered into the camps of some of our opponents. I asked them what they had against Dave. One of them scratched his head, and then said: 'Bill, I tell you Dave Murphey is one of the finest citizens, one of the finest doctors I have ever known in my life, and the only thing I can find against him is that he is just a little too young.' I replied: 'You have been reading the life of Sarah in the Bible instead of the life of Jesus. Sarah was 99 before she reached the height of her accomplishment and gave birth to Isaac, but Jesus Christ, the greatest humanitarian the world has ever known, did his greatest accomplishments before reaching the age of 30.'

"It gives me a great deal of pleasure to second the nomination of my fellow society member, David Murphey."

Dr. Payne: "Are there any further nominations?"

The Chair recognized Dr. Hugh West of the Volusia County Medical Society.

Dr. West: "I have in mind a man whom we, in Central Florida, think is just as good as anyone in the State. He is young—not too young; he is aggressive—not too aggressive. He has served this Association well."

"Our candidate is a past president of the Orange County Medical Society, a member of the Council of the State Medical Association, has served on numerous committees, has been a member of the Board of Governors, and former chairman of the Board of Governors. He has, since its very beginning, been a director of the Florida Medical Service Corporation. He has been eminently connected with all activities of the State Association for years. My candidate is prepared for and can well afford to give all the time necessary for a successful administration. He has been successful in his practice and is held in high regard by his contemporaries. He is a good man to be associated with, whether it is a business conference, a professional consultation or a social engagement. He is deserving and the honor of the presidency should be conferred on him. I am pleased to present my candidate, Dr. Duncan T. McEwan, for the office of president-elect."

The Chair recognized Dr. Homer Pearson of the Dade County Medical Association.

Dr. Pearson: "Let me say before I make my nomination that the Florida Medical Association has been most kind to me and has honored me to a much greater extent than I deserved; therefore, any proposal I make must be something I believe to be of advantage to this, my Association. I have never, during my years of membership, made a proposal or a nomination for any office which I felt was not for its definite improvement and advancement, nor will I ever do so. Let us bear in mind as we go into this election, that we must not be divided in our aims for its benefit; that this is a friendly election, with malice to none and good will to all."

"We have, with my nomination, three excellent candidates, any one of whom can and will represent us well, so let us have no hard feelings but resolve to support our president at all times,

no matter in which section of the state he happens to practice.

"I feel there is no doubt in anyone's mind whom I am going to nominate. Most of you have received a letter of introduction to John Milton, but for those who do not know him, I would like to review him briefly as a man.

"He was born in Georgia 52 years ago with a tin spoon in his mouth, the son of a minister (and I can talk about tin spoons and ministers all I please, because I am also the son of a minister, one of eleven children and we did not have enough tin spoons to go around). John was educated at Emory University. He came to Miami in 1925 and has practiced there for 25 years, and during those years of practice in Miami has been most active in organized medicine. He, too, has filled the important offices of his local county society. I cannot say as did one of the seconds to one of the men who has already been nominated that he has made no mistakes. He has his shortcomings, but I do say that he enjoys the respect, the love and the admiration of all those who know him. He is the immediate past president of the Dade County Medical Association, a society with a membership which is almost as large as the membership of the State Association when I became a member and when he became a member. He, too, was in the Armed Services during the Second World War, and I remember very well the time we received in our community the news that John Milton had been drowned. He was in the transport service, and someone had claimed to see the ship that he was on break into flames and he was lost. I am happy to say that was a grossly exaggerated statement, but for several days we were sad. We felt that we had lost one of our most important members. He was discharged from the Army as a Colonel, after having served honorably and well. I wish to solicit your support for a man who has exemplified in his life and practice those things that we hold are most important for one of our practitioners. He is capable, he is honest, he is decent, he is courteous, he is very well grounded, and is a practitioner of the Golden Rule."

Dr. Borland: "I am very happy to second the nomination of Dr. John Milton and to endorse the language in which it was couched, and I might state that it is a source of a good deal of pleasure for a man from Duval County to agree on something with a man from Dade County."

Dr. Hibbs: "I move that the nominations be closed."

Seconded by Dr. Butcher.

Motion to close nominations carried.

Dr. Payne: "Who is the new delegate that came in today?"

Dr. Paul: "Paul of Washington-Holmes."
(He was not seated in First House)

The Chair requested Dr. Jelks, chairman of the Credentials Committee, to call the roll.

The secretary, Dr. McIver, tabulated and reported 106 present.

The Chair ruled a secret ballot was in order and appointed Drs. Alvin L. Mills, William C. Roberts and Herbert L. Bryans as tellers.

The secretary announced the results of the first ballot: Dr. David R. Murphey, Jr., 52; Dr. Duncan T. McEwan, 19; Dr. John D. Milton, 34. (President Payne did not vote)

The Chair stated no nominee received a majority of all votes cast, as required by the By-Laws to elect.

Dr. McEwan: "I withdraw my name."

A delegate from the floor said, "No," and another, "He can't do that."

Dr. Fleming: "I move that Dr. McEwan be allowed to withdraw his name."

Seconded by Dr. Lamar. Motion carried.

Dr. Payne: "We will now proceed to ballot on Milton and Murphey."

Dr. McIver, the secretary, reported the results of the second ballot: Murphey, 64; Milton, 38.

Dr. Payne: "Dr. David R. Murphey, Jr., having received a majority of the votes cast, I declare him your president-elect and request Drs. William M. Davis and William M. Rowlett to escort Dr. Murphey to the platform."

Dr. Murphey: "I have seen other men in this circumstance many times and wondered how they felt. I have heard those before me try to express themselves, and it is now perfectly obvious why they have always been inadequate. My emotions are those of appreciation for the honors which you have bestowed on me combined with fear — not fear of being up here, but because I feel I am among friends — but fear of the job which we have before us. I am cognizant of the fact that that the fight does not end next Tuesday, and I pledge you, with your support and assistance, that we will carry on. I thank you."

Dr. Payne: "The next officer to be elected is that of first vice president. Nominations are in order."

Dr. Roberts: "I nominate Dr. Richard A. Mills."

It was moved and seconded that nominations be closed and the secretary cast the ballot for Dr. Mills.

Motion carried.

The Chair declared Dr. Mills the first vice president.

Dr. Payne: "Nominations are in order for second vice president."

Dr. Kenaston: "I nominate Dr. Walter C. Page."

Dr. Pearson moved that nominations be closed and the secretary cast the ballot for Dr. Page.

Seconded. Motion carried.

The Chair declared Dr. Page the second vice president.

Dr. Payne: "Nominations are in order for third vice president."

Dr. Rhodes: "I nominate Dr. James H. Pound."

It was moved and seconded that nominations be closed and the secretary cast the ballot for Dr. Pound. Motion carried.

The Chair declared Dr. Pound the third vice president.

Dr. Payne: "The next office is that of secretary-treasurer."

Dr. Bryans: "I would like to nominate the same secretary who is getting old on the job and I hope he doesn't die in office. I nominate Dr. Robert B. McIver."

Seconded by Dr. Hibbs.

It was moved and seconded that the nominations be closed and the president cast the ballot for Dr. McIver as re-elected secretary-treasurer.

Motion carried.

The chair declared Dr. McIver the secretary-treasurer.

Dr. Payne: "Nominations are in order for editor of The Journal."

Dr. Jere W. Annis: "I nominate Dr. Shaler Richardson."

Dr. Cason moved that nominations be closed, and that the secretary cast the ballot for Dr. Richardson.

Seconded. Motion carried.

The Chair declared Dr. Richardson the editor of The Journal.

Dr. Payne: "I would at this time like for Dr. Robert McIver and Dr. Charlie Collins to escort Dr. White to the platform."

Dr. Payne: "Dr. White, it now becomes my duty to relinquish the gavel. In so doing, I would like to make the statement that I made when I was elected president-elect, and that was that the privilege of wielding this gavel has been the greatest honor that I have ever received or shall ever receive.

"I am happy that I am able to pass this gavel on to a gentleman of your caliber. I would like to take this opportunity of expressing the hope that members of this Association, as I know they will, will give you the same cooperation that they have given me. That is the very best wish that I could give to you in turning this gavel over to you. May I take this opportunity of extending to you my very best wishes for a successful administration."

Dr. White: Mr. Past President, officers, members of the Florida Medical Association, members of the Woman's Auxiliary, ladies and gentlemen.

I can assure you this is a proud and very happy moment in my life. When I look back at the list of distinguished past presidents, at the rapid growth and activities of our association, and to the problems that lie ahead, it is with some humility that I accept this great honor. Each of the twenty-five years that I have been a member of the Florida Medical Association, I have seen the duties and responsibilities of the office of president increase to such an extent that I am overwhelmed with the magnitude of my job.

By the democratic Constitution and By-Laws of our Association each member has had a chance to vote for the officers of the Florida Medical Association. For your selection of me for this high honor I offer to each of you my humblest thanks, and I pledge with your support to continue the administration of the affairs of the Florida Medical Association with all the strength at my command.

The placid days when we had time to work out our own salvation are gone. We have awakened to find ourselves living in an era of racial, religious, and political confusion and unrest, with recurring wars and rumors of war that threaten the annihilation of the peoples of the earth.

With the support of some of our public servants, our government has a tendency to go "leftist," repudiating many of the principles upon which our democracy was founded, and instituting bureaucratic regimentation in many phases of public relations, including our own profession.

It is not consistent with its objectives and rules for the Florida Medical Association to take part in political campaigns, or to favor one candidate over another. It is, however, proper to urge the members of our non-political association — just as it is proper to urge all good citizens — to familiarize themselves with political issues and candidates, in order that they may be better able intelligently to exercise their right and duty to vote. All of us must assume the responsibility to investigate, learn the true facts, vote our convictions, inform our neighbors and persuade them to vote with us.

We can win the fight this year, and discourage future attacks on our profession, by filling the ballot boxes with the votes of honest and intelligent people. The results of the primary election on May second will very vitally affect every one of us. Our votes and influence will, undoubtedly, be the deciding factor.

**Presentation of Past-President's Button to
Dr. Walter C. Payne by Dr. Herbert E. White,
the new President**

Walter, having been closely associated with you during the past year, I know you have had many pleasant, and some unpleasant, duties to perform. I am very glad to know that my first duty as president is a most pleasant one.

According to the By-Laws of our Association, your term of office as the REAL Head of the Profession in the State has come to an end. However, we are very glad that the By-Laws further provide that the association will continue to have your advice and counsel as a member of the Board of Governors for the next two years.

Many years ago, the officers of our association recognized the fact that the Past-President should have more than the privilege of attending the Past-President's annual breakfast to honor him for his services to the Florida Medical Association. To this end, at the fortieth annual session, held in Miami on April 14, 1913, a motion was offered by the late Dr. Ralph Greene that the Past President's Button should be designed, and a special committee of Drs. Turck, McGinnis and Fernandez was appointed for this purpose. I am sure the majority of our members realize the objectives that this committee had in mind when they designed this button.

In following the custom of our association, it is with the greatest pleasure that I present you with this Past President's Button. I am sure when you wear this, you will know it is a symbol of the deep appreciation of every member of our association for your years of service.

In further recognition of service, the association awards each retiring president a Certificate of Honor. In the

years to come, Walter, as you look upon the walls of your office, this certificate will be a reminder of the esteem and affection held for you by all members of our Association.

Dr. White: "By way of information, I would like to say that the next annual meeting of the Florida Medical Association will be held in the Hollywood Beach Hotel, Hollywood, April 22-25, 1951, so far as the Board of Governors knows at the present time."

Dr. White: "Is there any further business to come before the House?"

Dr. Kenaston: "Members of the House of Delegates, we have had a most wonderful convention here and before we adjourn, I think we should have a rising vote of thanks to those who have made it possible."

All members of the House rose to their feet in an expression of appreciation.

There being no further business, on motion by Dr. Joseph S. Stewart, duly seconded and carried, the House of Delegates adjourned, sine die, at 12:50 p.m.

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:15 a.m., Monday, April 24, in The Sun Room with Dr. Frederick K. Herpel of West Palm Beach presiding. The following papers were read and discussed:

"Cancer of the Head and Neck," J. Brown Farrior, Tampa.

"Principles of Plastic Surgery," George W. Robertson, Miami.

"Proctoscopic Color Movies," J. Peerman Nesselrod, Evanston, Illinois and Jay M. Garner, Winnetka, Illinois.

"Treatment of Pelvic Malignant Disease," Emil Novak, Baltimore.

"Spontaneous Internal Biliary Fistulae," Donald W. Smith, Maurice M. Greenfield and Martin G. Gould, Miami.

Second Scientific Assembly

The second Scientific Assembly convened at 3:30 p.m., Monday, April 24, in The Sun Room with Dr. Jere W. Annis of Lakeland presiding. The following papers were read and discussed:

"Differential Diagnosis of Low Back Pain," Ralph Herz, Key West.

"Cytologic Diagnosis of Malignant Disease," Nelson A. Murray, Jacksonville.

"Chronic Pyuria in Infants and Children," Meredith Campbell, New York.

"Roentgen Examination in the Acute Condition within the Abdomen," Floyd K. Hurt and Bert H. Malone, Jacksonville.

Third Scientific Assembly

The third Scientific Assembly convened at 2:15 p.m., Tuesday, April 25, in The Sun Room with Dr. James L. Borland of Jacksonville presiding. The following papers were read and discussed:

"Management of Cardiac Failure," George F. Schmitt, Miami.

"Diagnosis in Heart Disease," Elwyn Evans, Orlando.

"Medical Planning for Atomic Disaster," Col. William L. Wilson, U. S. Army, Washington, D. C.

"Dietary Treatment of Hypertension through Sodium Restriction," M. Jay Flipse, M. Eugene Flipse, and Otto W. Burtner, Miami.

"Subdiaphragmatic Abscess with Special Reference to its Roentgen Visualization," Frederick H. Bowen and Arthur L. Hardie, Jr., Jacksonville.

"Medical Aspects of Blindness in Children," Nathan S. Rubin, Pensacola.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at

9:00 a.m., Wednesday, April 26, in The Sun Room with Dr. James R. Boulware, Jr., of Lakeland presiding. The following papers were read and discussed:

"The Diagnosis and Treatment of Diseases of the Chest, with Emphasis on the Value of Consultation," Turner Z. Cason, Jacksonville.

"Viral Hepatitis: Present Concept and Some of Its Problems," Henry Fuller, Lakeland.

"Nummular Eczema, Its Differential Diagnosis and Treatment," Burton F. Barney, West Palm Beach.

REGISTRATION

The registration for the Seventy-Sixth Annual Meeting at Hollywood surpassed that of any previous convention of the Association. The total number registered was 1,377 persons. The registrants included 735 members of the Association, 110 visiting physicians, 16 other guests, 373 members and guests of the Woman's Auxiliary and 143 representatives of exhibiting firms. An interesting note is the excellent representation of other states. Twenty-one states, the District of Columbia and Canada were represented.

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(Continued on page 785)

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HERBERT EUGENE WHITE, M.D., PRESIDENT

Dr. Herbert Eugene White was born in Flovilla, Ga., on Oct. 28, 1897. He attended preparatory school at the Marist College in Atlanta, finished his premedical education at the University of Georgia in Athens and received his medical degree from Emory University School of Medicine in Atlanta on June 3, 1923. Following graduation, he was honored by having his license to practice medicine in Georgia signed by his father, Dr. A. F. White, who was then president of the Georgia State Board of Medical Examiners and had been a member of that board for twenty-eight years. Dr. White served an internship and then a residency in surgery at Grady Hospital in Atlanta before beginning private practice in St. Augustine on Feb. 18, 1925.

Since 1933, Dr. White has been Chief of the Surgical Staff of Flagler Hospital in St. Augustine. He is a past president of the St. Johns County Medical Society and also of the Chattahoochee Valley Medical Society.

Dr. White has served the Florida Medical Association in various official capacities. He has been a Councilor and was chairman of the Council for one year. For a number of years he has been a member of the Committee on Scientific Work and was for seven years its chairman. In 1948 he was the Association's First Vice President and in 1949 the President-Elect; and now that he assumes the presidency, he also becomes chairman of the Board of Governors by virtue of his office.

A life member of the American College of Surgeons, Dr. White is also a member of the American Medical Association, the Southern Medical Association, the Southeastern Surgical Congress and the International College of Surgeons. His fraternities are Phi Delta Theta and Phi Rho Sigma.

The Journal of the Florida Medical Association

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Seventy-Sixth Annual Meeting A Great Success

Under the able leadership of our retiring president, Dr. Walter C. Payne, the recent meeting of the Florida Medical Association in Hollywood was not only the largest in point of attendance, but almost surely was the most successful in the long history of the Association.

The scientific assemblies could have had better attendance and probably will as the caliber of the program improves further and becomes better known. Likewise, the President's inspired address should have been heard by many more members—in fact, by every member in the Association. Those who did not have the opportunity to hear this message, which stemmed from deep in the character of the man himself, will want to read it in this issue of The Journal and reflect upon each thought-provoking passage.

The manner in which the three reference committees reviewed reports, studied pros and cons of proposed legislation, and made recommendations after due reflection upon those issues which were necessarily somewhat controversial, inspired the respect of each member of the House of Delegates. Older members of the Association will remember the tedious sessions in the House of Delegates prior to establishment of the reference committee system, when less was accomplished in a much longer time. They can appreciate even more than other members the manner in which these committees went about the task of expediting the business at hand.

The almost maximal attendance in the House of Delegates at each session was as it should have

been, as was also the spirited voting without rancor.

The exhibits were good. The entertainment was never better.

To all of those who had a part in making this our biggest and best annual meeting we offer our thanks and congratulations. The smoothness with which the meeting progressed bespoke the usual capable management.

We have a date for next April. It's Hollywood again. Let's make our reservations early.

Progress At The Annual Meeting

Reference Committee 3 of the House of Delegates, headed by its able chairman, Dr. Walter C. Jones, might well be singled out for special commendation for its constructive service at the recent annual meeting. Aided by Dr. Robert B. McIver, the Secretary-Treasurer, who presented in graphic form the facts in regard to the present state of our finances and the funds which must be forthcoming if the Association is to continue to progress in an outstanding manner, the Committee recommended an increase in dues from \$25 to \$40 annually, effective January 1, 1951, which was voted by the House of Delegates with little discussion.

Likewise, after recommendation from the Reference Committee, the House voted overwhelmingly to admit Negro physicians to membership in the Florida Medical Association on the same basis as present members. The Association will welcome Negro Doctors of Medicine as members

and will feel genuinely glad that they may participate in the privileges and advantages which the scientific sessions afford. Through this action the rate of progress and improvement in the quality of medical practice throughout Florida can be accelerated.

Television in Medical Education

Now that the whole nation is rapidly becoming television-conscious from the entertainment viewpoint, the educational value of this new device is also coming to be appreciated. Certainly television is one of the most important developments now going on in the field of medical education. A recent survey indicates that the vast majority of physicians prefer television to motion pictures, particularly in the teaching of surgery, because, if it is properly presented, the viewer almost literally looks over the surgeon's shoulder during the operation. One medical leader observed humorously that a time might conceivably come "when the student will merely stay at home and take his medical education by osmosis."

Color of course adds the factor of intrinsic interest in television. The highly important questions of what color transmission method should be adopted as the standard system and how it should be grafted onto the present black and white pictures are at present the subject of continuing exploration. Evidence of the keen interest in color television in medical circles was apparent at the Atlantic City meeting of the American Medical Association last June for the color television show attracted more than 30,000 visitors. Occasionally the color image was changed to black and white, and the contrast was striking. At the meeting in San Francisco this month, interest will no doubt be greatly enhanced.

In medicine, color television as a teaching medium has great potentialities. Not only are surgical procedures reproduced satisfactorily but roentgenograms also can be reproduced with a high degree of accuracy by varying the density and contrast control on the receiver. Television comes at a time when medical educators are beginning to appreciate and understand the intelligent use of motion pictures. This latest milestone of progress in the evolution of visual education will, however, not replace them, but will contribute to the advancement of medical teaching in its proper sphere as it is coordinated and integrated with other technics of teaching.

Better Public Relations

The establishment of a Grievance Committee on a statewide level is an important step forward in the Association's progress. This action, sponsored and urged by Dr. Walter C. Payne as he concluded his tenure of office as president, was taken at the annual meeting in April.

It seldom hurts a body to admit its errors. The fact that the majority of the members are willing and eager to arbitrate and adjust misunderstandings and complaints is a contribution toward the betterment of public relations that should prove to be of major importance.

Labeling Requirements For Prescriptions

The Bureau of Professional Relations of the College of Pharmacy of the University of Florida, through its Director, Dr. P. A. Foote, recently has sent a communication to the Association concerning labeling requirements for prescriptions.

Two legal cap-sized, closely mimeographed pages list requirements for prescription labeling which have been laid down by the Federal Food, Drug and Cosmetic Act and the Federal Narcotic statutes. Mr. F. A. Duckworth, Instructor in Pharmaceutical Jurisprudence, and Mr. C. S. Haupt, Associate Director, Bureau of Professional Relations, College of Pharmacy, who prepared this report, remind the physician that there has been a great deal of controversy in recent months over what is required by federal and state laws on the subject and point out that the report is offered so that Florida pharmacists and physicians may better understand what is required of them. They suggest that when a physician writes a prescription for a habit-forming drug, or for one whose sale is restricted, he mark in the lower left hand corner of the prescription blank the number of times he would like that prescription to be refilled.

Medical Golf Tournament

Winning the Orlando Loving Cup in a field of 80 golfing doctors at Hollywood Beach Country Club this year was Dr. W. G. Meriwether of Plant City with a score of 79 less 17 for a net 62. Dr. Meriwether was also winner of low gross in Division C (handicaps 14 to 21).

Other winners were J. L. Hundley of Orlando, low gross of 72 for Division A (handicap 6 and under); Carl E. Dunaway, Miami, low gross of 76 for Division B (handicap 7 through 13); and Nathan Weil, Jacksonville, low gross 87 in Di-

vision D (handicap 22 and over).

Prizes for low net scores figured on Shawnee handicaps system were J. D. McKey, Orlando, and Curtis Benton, Jr., Fort Lauderdale—68; J. C. Hayward, Orlando, and L. J. Netto, West Palm Beach—72; Frank Gray, Orlando; and M. A. Lischkoff, Pensacola—72; and T. A. Snow, Gainesville, and Franz Stewart, Miami—74.

Highest scorer in the tournament was Duncan McEwan, Orlando, who was awarded a consolation prize for his round of 105.

Prizes were presented at the Association Dinner at the Hollywood Beach Hotel, Tuesday night, April 25th, and consisted of sport shirts and golf balls plus a jacket for the lowest scorer, J. L. Hundley.

Dr. Dodge Mentzer, last year's cup winner, turned over the Orlando Loving Cup to Dr. Meriwether for safe keeping during the coming year.

Local Golf Committee

Curtis D. Benton, Jr., *Chairman*

Pan American Ophthalmology- Antib blindness Meeting

The Pan American Association of Ophthalmology and the National Society for the Prevention of Blindness met jointly at the Floridian Hotel in Miami Beach, March 26-31, 1950. Dr. Conrad Berens, President of the Pan American Association of Ophthalmology, and several hundred ophthalmologists from the United States, Canada and Latin America gathered there to participate in this first meeting of the kind with Mason H. Bigelow, President of the National Society for the Prevention of Blindness, and many representatives of that organization.

Appearing on the program of this joint sight-saving conference were nearly 100 speakers, of whom 32 were physicians from nine Latin American countries, including Cuba, Brazil, Uruguay, Argentina, Chile, Peru, Mexico, Guatemala and Puerto Rico. All sessions were conducted in two languages by two presiding officers, one from a Spanish-speaking country and one from the United States or Canada. Highlight of the conference was a luncheon address on March 28 by Gen. George C. Marshall, wartime Chief of Staff and later Secretary of State.

Dr. Bascom H. Palmer of Miami served as chairman of the Florida arrangements committee. Assisting him were Dr. Shaler Richardson of Jacksonville, Dr. Sherman B. Forbes of Tampa and Dr. William Y. Sayad of West Palm Beach.

Eighteenth Annual Graduate Short Course June 26-July 1, 1950

The Eighteenth Annual Graduate Short Course for the physicians of Florida and their guests, the pharmacists of the state, will be held at the George Washington Hotel in Jacksonville during the week of June 26, 1950. This Short Course is presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health.

An innovation this year is a series of lectures on pharmaceutical advances, arranged in response to the particular interest of the medical profession in the newer drugs and present pharmaceutical research. It is planned to further closer relations between the professions of pharmacy and medicine and is a healthful sign of mutually beneficial cooperation between the two professions.

The following members of the faculty will present the lectures for the week: **MEDICINE:** Dr. Chester S. Keefer, Wade Professor of Medicine, Boston University School of Medicine Physician-in-Chief, Massachusetts Memorial Hospitals, Boston; **PEDIATRICS:** Dr. Samuel F. Ravenel, Dean of the Southern Pediatric Seminar, Saluda, N. C., Greensboro, N. C.; **OBSTETRICS:** Dr. Oren Moore, Dean of Southern Obstetrical Postgraduate School, Charlotte, N. C.; **GYNECOLOGY:** Dr. Andrew A. Marchetti, Professor and Chairman of the Department of Obstetrics and Gynecology, Georgetown University School of Medicine, Washington, D. C.; **SURGERY:** Dr. Herbert D. Adams, General and Thoracic Surgeon, Lahey Clinic and Associated Hospitals, Boston; and **PHARMACEUTICAL ADVANCES,** Dr. Perry A. Foote (Ph.D.), Dean of College of Pharmacy and Director of Bureau of Professional Relations, University of Florida, Gainesville; Dr. Werner M. Lauter (Ph.D.), Professor of Pharmaceutical Chemistry, College of Pharmacy, University of Florida, Gainesville; Dr. Elbert Voss (Ph.D.), Head Professor of Pharmacognosy and Pharmacology, College of Pharmacy, University of Florida, Gainesville; Mr. Frank A. Duckworth (B.S.Pharm., B.L.), Instructor, Commercial Pharmacy and Pharmaceutical Jurisprudence, College of Pharmacy, University of Florida, Gainesville.

The complete schedule is presented on page 780.

Schedule of the Short Course

HOUR	Monday June 26	Tuesday June 27	Wednesday June 28	Thursday June 29	Friday June 30	Saturday July 1
8:00	Registration					
9:00	Pharmaceutical Advances Research Leading to Modern Therapy Dr. Lauter	Pediatrics Infant Feeding Dr. Ravenel	Pediatrics Treatment of Acute Infections Dr. Ravenel	Obstetrics Minor Ailments of Pregnancy Dr. Moore	Gynecology Intraepithelial Carcinoma of the Cervix Dr. Marchetti	Gynecology Surgery of the Ovary Dr. Marchetti
10:00	Pediatrics Office Practice Dr. Ravenel	Pharmaceutical Advances New Therapeutic Agents in 1949 Dr. Voss	Obstetrics Prenatal Care Dr. Moore	Gynecology The Menopause and Its Management Dr. Marchetti	Obstetrics Discussion of Reid's Method Dr. Moore	Surgery The Surgical Management of Portal Hypertension and Associated Hemorrhage Dr. Adams
11:00	Recess	Recess	Recess	Recess	Recess	Recess
11:30	Medicine Modern Antibiotic Therapy in Infectious Diseases Dr. Keefer	Medicine Hypertension: A Discussion of Its Pathogenesis and Treatment Dr. Keefer	Medicine Vitamin and Hormone Therapy Dr. Keefer	Surgery Surgery of the Upper Gastrointestinal Tract Dr. Adams	Surgery Surgery of the Major Blood Vessels and the Heart Dr. Adams	Gynecology Myoma and Other Benign Lesions of the Uterus Dr. Marchetti
12:30	Lunch	Lunch	Lunch	Lunch	Lunch	Surgery The Surgery of Goiter Dr. Adams
2:00	Pediatrics Immunization and Prophylaxis Dr. Ravenel	Pediatrics Poliomyelitis Dr. Ravenel	Pediatrics Vomiting and Diarrhea Dr. Ravenel	Obstetrics Analgesia and Anesthesia in Labor Dr. Moore	Obstetrics Episiotomy and Outlet Forceps Dr. Moore	
3:00	Recess	Recess	Recess	Recess	Recess	
3:15	Pharmaceutical Advances Preparation of Drugs Dr. Lauter	Pharmaceutical Advances Drug Laws and Regulations Mr. Duckworth	Medicine Cardiovascular and Diuretic Agents Dr. Keefer	Gynecology Urinary Incontinence in the Female Dr. Marchetti	Surgery Surgical Diseases of the Lungs Dr. Adams	
4:15	Recess	Recess	Recess	Recess	Recess	
4:30	Medicine Cortisone and ACTH: Their Present Position in Clinical Medicine Dr. Keefer	Medicine Spasmolytic and Histaminolytic Drugs: Their Place in Medical Therapeutics Dr. Keefer	Obstetrics Bleeding in Pregnancy Dr. Moore	Surgery Surgical Aspects of Ulcerative Colitis Dr. Adams	Gynecology Dysmenorrhea Dr. Marchetti	
	Dinner	Dinner	Dinner	Dinner	Dinner	
8:00	Pharmaceutical Advances Interprofessional Relations Dr. Foote	Medical Round Table Discussion		Surgical Round Table Discussion		

STATE NEWS ITEMS

The April issue of the monthly bulletin of the Duval County Medical Society carries an outstanding editorial entitled, "Crisis." The substance of the editorial is an exhortation to the members of the society to exercise their rights and privileges as citizens in order that the free practice of medicine may be preserved.

Dr. James L. Anderson of Miami recently was a guest of WGBS's Alan Courtney program. Dr. Anderson discussed what he terms a psychiatrist's-eye-view of the trend toward socialism and government control. The radio audience kept him busy nearly two hours answering questions on medicine and health insurance.

Dr. Samuel M. Day, Jr., Jacksonville, discussed the subject of gastrointestinal ulcers at the March meeting of the Men's Club of the local YMCA.

Dr. Gretchen V. Squires of Pensacola was one of the speakers in a series of broadcasts on cancer over radio station WBSR. Dr. Squires' subject was "The Case of the False Clues."

Dr. George F. Hieber of St. Petersburg recently spoke before the local women of Rotary on the subject, "You and Your Skin." With the assistance of lantern slides, he explained the more common skin diseases.

Dr. John O. Rao, Kissimmee, recently addressed the local Lions Club on the subject of cancer.

Dr. Clyde O. Anderson of St. Petersburg has been elected president of the University of Florida Alumni Association.

The 1950 Post Graduate Assembly in Endocrinology including Diabetes was held at the Roney Plaza Hotel, Miami Beach on April 3-8. A distinguished faculty of twenty-two professors gave a very intensive course of lectures, laboratory and clinical demonstrations to a group of 170 physicians from the United States, Canada and various Latin American countries.

One of the highlights of this event was a symposium on ACTH, Cortisone and other compounds in the treatment of various pathological conditions, presented by Drs. Hans Selye and J. S. L. Browne, of Montreal and George Thorn, of Boston. Another important feature was the symposium on Hyperthyroidism by Drs. Frank Lahey, Boston; Paul M. Starr, Los Angeles; E. Perry McCullagh, Cleveland, and Samuel F. Haines of the Mayo Foundation.

The high interest shown by the graduate students has suggested the holding of this annual Assembly again in Miami in the near future. The Association for the Study of Internal Secretions and the American Diabetes Association are the sponsors. Dr. Carlos P. Lamar of Miami acted as Chairman for local organization and Latin American relations.

Drs. John P. Ferrell, Henry J. Jensen and Irwin S. Leinbach of St. Petersburg were on the program of the semi-annual convention of the Florida Society X-ray Technicians held at the Soreno Hotel in St. Petersburg.

Dr. Leon S. Eisenman of Okeechobee spoke on new discoveries of medicine at a recent meeting of the Okeechobee Rotary Club. Dr. Eisenman discussed new antibiotics and other recently developed drugs.

Dr. Frank G. Slaughter of Jacksonville has been re-elected president of the Tuberculosis Association of Duval County.

Index to

Volume XXXVI

Page 788

Dr. Lucien Y. Dyrenforth of Jacksonville presided at the third annual meeting of the Florida Association of Blood Banks at Ponte Vedra Beach, May 13-14. The subject of the conference was "Blood Transfusions and Their Relation to Anesthesia."

Dr. Claude C. Pearce of Mulberry has had his years of outstanding service to his community recognized by having the new public library named The Pearce Library.

Association members who attended the annual conference of the Florida Tuberculosis and Health Association in Panama City, March 30-31 were Drs. Turner Z. Cason, Clarence M. Sharp, and Wilson T. Sowder, Jacksonville; Robert G. Head, Daniel A. McKinnon and Elmer J. Teagarden, Marianna; DeWitt C. Daughtry, Miami; Thomas C. Black, William O. Fowler, and Lawrence H. Kingsbury, Orlando; John C. McSween, Jr., Pensacola; Frank L. Quillman, Sanford, and Leffie M. Carlton, Jr., and Arthur D. Draper, Tampa.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abrashkin, Mortimer D., Miami Beach
Brown, Delmer J., Orlando
Brown, Edwin W., West Palm Beach
Brown, Marion S., Orlando
Groom, Dale S., Coral Gables
Hanson, James R., Wildwood
Harris, J. Edward, Sarasota
Hauss, John F., Miami Beach
Kennedy, David R., Sarasota
Mitchell, John T., Panama City
Neal, Edwin G., Miami
Phillips, William C., Coral Gables
Piper, Robert C., Miami
Poyner, James A., Panama City
Sewell, James A., Melbourne
Shackelford, W. Lawson, West Palm Beach
Skinner, Louis C., Jr., Coral Gables
Trygstad, Reidar, Naples
Van Tilborg, Laurance D., Fort Pierce

BIRTHS AND DEATHS

Births

Dr. and Mrs. William J. Phelan of Jacksonville announce the birth of a son, John Edward, on April 12.

Dr. and Mrs. Manuel A. Schofman of Miami announce the birth of a daughter.

Drs. Henry A. and Lillian C. Mark of Jacksonville announce the birth of a daughter, Frances Rae, on March 9.

Deaths — Members

Brinson, William D., Baldwin April 15, 1950

Deaths — Other Doctors

Butchart, Thomas R., Tampa March 30, 1950

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

David R. Murphey, Jr., of Tampa, Brooksville Kiwanis Club

Irwin S. Leinbach of St. Petersburg, local Kiwanis Club

Harry R. Cushman of St. Petersburg, local Kiwanis Club

Homer L. Pearson, Jr., of Miami, Hialeah-Miami Springs Lions Club

Charles McD. Harris, Jr., of West Palm Beach, local Hi-Y Club

Reuben B. Chrisman, Jr., of Miami, Southeastern Pharmaceutical Association meeting in Miami

Irwin S. Leinbach, St. Petersburg, local Young Republican Club

Lester L. Whiddon, Ft. Pierce, Fairlawn Parent-Teacher Association

Edward R. Annis, Miami, Ft. Lauderdale War Memorial Auditorium

Chester H. Murphy, Bartow, local Lions Club

COMPONENT SOCIETY NOTES

Duval

The Duval County Medical Society held its regular monthly meeting on Tuesday, April 4, in the Sellers Auditorium, Jacksonville.

On the scientific program, Drs. Arthur L. Hardie, Jr., and Frederick H. Bowen presented a paper on "Subdiaphragmatic Abscess with Special Reference to X-Ray Visualization." In addition, Dr. Ralph N. Greene spoke on the subject, "Trends in Ocular Prosthetic Surgery."

Franklin-Gulf

All members of the Franklin-Gulf County Medical Society have paid 1950 dues.

Jackson

The Jackson County Medical Society held its March meeting in Marianna with President James T. Cook presiding.

Guest speakers were Dr. David James of Emory University Hospital, who spoke on the subject, "Differential Diagnosis of Jaundice," and Dr. John Adriana, New Orleans, whose subject was "Anesthesia in General Practice."

In addition to the out-of-state guests, Dr. Walter C. Payne, Pensacola, appeared on the same program.

Lake

State dues for 1950 have been paid by all members of the Lake County Medical Society.

Marion

The Marion County Medical Society held a joint meeting with the Woman's Auxiliary at the Elks Club in Ocala on April 19. Guest speaker for the evening was Dr. L. A. Brendle, director of the Marion County Health Unit. Members present were Drs. William H. Anderson, Jr., Hugh H. Barfield, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Henry L. Harrell, Carl S. Lytle, John N. Moore, John P. Moore, Robbins Nettles, Eugene G. Peek, Jr., and Ralph E. Russell, Ocala; James L. Strange, McIntosh, and Clifford E. Vinson, Williston. Guest doctors were Dr. Brendle and Dr. Jere W. Kirkpatrick, Inverness.

Pinellas

The Pinellas County Medical Society held its regular monthly meeting at the Detroit Hotel, St. Petersburg, on April 3.

On the scientific program, Dr. Virgil C. Daniels, Jr., spoke on "Chronic Constrictive Pericarditis." His paper was discussed by Drs. Thomasson P. Dann, James L. Gouaux and Sidney Grau.

The current issue of the Picomeso Mail Bag of the Pinellas County Society carries an article on "Peridontia" by Wallis D. Caswell, D.D.S.

Putnam

All members of the Putnam County Medical Society have paid 1950 membership dues.

Suwannee

State dues for 1950 have been paid by all members of the Suwannee County Medical Society.

YOUR BLUE SHIELD

Blue Shield Annual Meeting

Election of Board Members

The annual meeting of the Active Members of the Florida Blue Shield Plan was held on April 23, 1950 in Hollywood, Florida, prior to the annual meeting of the Florida Medical Association. Four doctors and two laymen were elected by the active members to fill vacancies on the Board of Directors, which vacancies were brought about by the expiration of six terms of office. Those elected to serve for terms of three years each on the Board of Directors are: Dr. Duncan T. McEwan, Orlando; Dr. Eugene G. Peek, Ocala; Dr. Herbert E. White, St. Augustine; Dr. William M. Rowlett, Tampa; Mr. C. DeWitt Miller, Orlando and Mr. H. Plant Osborne, Jacksonville.

Election of Officers

At the annual meeting of the Board of Directors held immediately following the meeting of active members, the following officers were re-elected for the ensuing year: Dr. Leigh F. Robinson, Ft. Lauderdale, President; Dr. Walter C. Jones, Miami, First Vice-President; Mother Loretta Mary, St. Joseph's Hospital, Tampa, Second Vice-President; Dr. Herbert E. White, St. Augustine, Secretary and Dr. Frederick J. Waas, Jacksonville, Treasurer.

Blue Shield Progress During 1949

In his annual report to the active members, H. A. Schroder, Executive Director, advised that during 1949 Blue Shield enrolment growth was greater than in any other year since the organization of the Plan with the addition of 69,232 members, and that present enrolment was 170,863 members. The Executive Director's annual report further showed that during 1949, a total of \$661,531.10 had been paid to doctors for the care of Blue Shield members.

Speaking on the outlook for Blue Shield for 1950, Mr. Schroder stated that the splendid response and acceptance given the new Series "7" contract indicated that 1950 would be a successful year from a financial as well as an enrolment standpoint.

Individual Enrolment

The enrolment of individuals in the Blue Shield and Blue Cross Plans was the topic of a general discussion which followed the regular or-

der of business. Active members were given a report on the first Blue Shield-Blue Cross non-group enrolment drive which had been conducted in Polk County during March, and were advised of plans for similar drives to be conducted in three other counties. The Executive Director explained that after the first four drives had been completed, non-group enrolment would not be offered in other counties for a few months in order that the Plans might determine the experience on such enrolment, and that if the enrolment of individuals was found to be satisfactory, Blue Shield and Blue Cross would then be offered on a non-group basis throughout the state in county-wide enrolment drives.

OBITUARIES

James Leroy Chalker

Dr. James L. Chalker of Ocala died on March 13, 1950 following an illness of nine years. He was 65 years of age.

A native Floridian, Dr. Chalker was the son of James Lexington and Margaret Allie Chalker. He was born and reared at Bellmore near Green Cove Springs. After attending the University of Florida at Lake City, he entered the Medical College of the State of South Carolina and received his medical degree there in 1912.

For eight years Dr. Chalker practiced in Green Cove Springs and then served for four years as the state physician at Raiford. In 1924 he moved to Ocala, where he practiced for seventeen years until ill health forced his retirement. He was a Mason and a member of the First Baptist Church.

Dr. Chalker was a member of the Marion County Medical Society, holding honorary membership since his retirement. He became a member of the Florida Medical Association in 1923, served as councilor of his district from 1927 to 1929 and during his long illness held honorary status. He was also a member of the American Medical Association.

Survivors include the widow, Mrs. Cephus Fore Chalker of Ocala; five daughters, Mrs. Margaret Capell of Atlantic Beach, Mrs. Dorothy Plumley of Warner Robins, Ga., Mrs. Frances Niblack and Miss Betty Sue Chalker of Ocala, and Mrs. Annie Belle Bratcher of Leesburg; one

son, James L. Chalker, Jr., of Ocala; one brother, O. G. Chalker of Daytona Beach; and one sister, Mrs. Pearl Gray of Ocala. Six grandchildren also survive.

John Ewell Hall

Dr. John E. Hall of Miami died in a local hospital on March 11, 1950. He was 72 years of age.

Born in 1878, Dr. Hall was graduated from the Tulane University of Louisiana School of Medicine in 1908. Upon completion of postgraduate work under Dr. Ballentine, he practiced a short time in Phillip, Miss., before locating in Nashville, Tenn., in 1915. He engaged in the practice of medicine there until 1925, when he moved to Florida. He practiced in West Palm Beach for three years before locating in Miami, where he practiced for twenty years before retiring two years ago.

Dr. Hall, who for forty years served the public in his chosen profession of urology, had the distinction of being the first member of the American Urological Society to practice in Florida. He was a veteran of the Spanish-American War and World War I, a charter member of Miami Beach American Legion Post 85 and a member of the 40 & 8.

This pioneer urologist was a past president of the Dade County Medical Association. He was a member of the Florida Medical Association and served as councilor of his district in 1926 and 1927. He also held membership in the American Medical Association, the Southern Medical Association and the American Urological Society.

Surviving are his widow, Mrs. Ina Dunlap Hall, and one daughter, Miss Laura Louise Hall, both of Miami.

John A. Hardenbergh

Dr. John A. Hardenbergh of St. Petersburg died on March 1, 1950 at the age of 71.

He was born at Millheim, Pa., March 22, 1878. After graduation from Franklin and Marshall College in 1898, he enrolled in the University of Pennsylvania School of Medicine and received his medical degree in 1905. He practiced in his birthplace until he came to Florida in 1921. Dur-

ing World War I he served overseas with the Twenty-Eighth Division of the Army.

Until his retirement two years ago, Dr. Hardenbergh was on the staffs of the Mound Park and St. Anthony's hospitals. He did general practice, majoring in obstetrics and cardiology.

Dr. Hardenbergh was a past president of the Pinellas County Medical Society and had held membership in the Florida Medical Association since 1926. He was also a member of the American Medical Association.

Elliott Miley Hendricks

Dr. Elliott M. Hendricks of Ft. Lauderdale died in Broward General Hospital from a massive myocardial infarction on Feb. 28, 1950 after a long illness. He was 52 years of age.

Born in Cincinnati, on July 9, 1897, Dr. Hendricks was also educated there. He received the B.S. and A.B. degrees from the University of Cincinnati and, in 1922, the M.D. degree from the College of Medicine of that institution. After interning at Cleveland City Hospital, he served as radiologist at White Cross Hospital, Mt. Carmel Hospital and Franklin County Sanatorium in Columbus, Ohio, during 1924 and 1925. During World War I he saw service in the infantry and in World War II was a member of the Selective Service Board.

In 1926 Dr. Hendricks came to Ft. Lauderdale as superintendent of Edwards Hospital and continued to practice there until he retired in 1945 because of ill health. He was a founder and for years chief of the radiology department of Broward General Hospital. From 1928 until 1945 he was a surgeon of the United States Public Health Service at the Coast Guard Base 6 and Port Everglades, and Immigration Official for Port Everglades. A leader in civic and fraternal organizations and in business, he developed Hendricks Island and Hendricks Heights, and in 1940 established the H. A. K. Products Company, which manufactured munitions. He was a member of the American Legion, a Mason, an Elk and a past president of the Kiwanis Club.

Dr. Hendricks was a member of the Broward County Medical Society, the Florida Medical Association and the American Medical Association. He served the state society as councilor of

his district in 1932 and from 1944 through 1948. He was a fellow of the American College of Radiology and councilor for the Florida District, a member of the North American Radiological Society and a charter member of the Florida Radiological Society. Also, he held membership in the Society of Seaboard Surgeons.

Surviving are his widow, Della C. Hendricks, a daughter, Dr. Anne Hendricks McCurdy, his mother and stepfather, Mr. and Mrs. Harry E. Barnes, all of Ft. Lauderdale; a sister, Mrs. Robert Smith of Cincinnati; two brothers, Dr. Louis J. Hendricks of Cincinnati and Dr. Anthony B. Hendricks of Biloxi, Miss.; a stepbrother, Edwin H. Barnes of Ft. Lauderdale; and three grandchildren, Elizabeth, Elliott and Richard McCurdy.

(Continued from page 774)

Robert H. Hutchinson. TAMPA: Luis A. Barreras. Geo. H. Schoetker, Lynwood B. Smith, Harold Sutker, James A. Winslow, Jr. WEST MIAMI: Bernard Yesner. WEST PALM BEACH: Joseph J. Daversa, John F. Wymer, Jr.

ALABAMA—DOTHAN: Jno. T. Ellis. CANADA—MONTREAL: L. H. McKim. DELAWARE—WILMINGTON: A. R. Shands, Jr. GEORGIA—CUTHBERT: J. C. Patterson. DECATUR: Lucille J. Marsh. EMORY UNIVERSITY: Robert P. Kelly. MARIETTA: M.M. Hagood. VALDOSTA: James L. Campbell. ILLINOIS—BLOOMINGTON: Edmund J. Colson. CHICAGO: Ernest M. Grochowski, Robert Reich, Philip Thorek. EVANSTON: G. J. Fitzgerald. WILMETTE: J. Peerman Nesselrod. WINNETKA: Jay M. Garner. INDIANA—JEFFERSONVILLE: John H. Baldwin. LOUISIANA: B. J. LaCour, Jr. NEW ORLEANS: Alton Ochsner. MARYLAND—BALTIMORE: Emil Novak. MASSACHUSETTS—BOSTON: Samuel H. Marder. MICHIGAN—LANSING: C. Ray McCorvie. MUSKEGON: Devere R. Boyd. YPSILANTI: Harold W. Martin.

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Other Guests

JACKSONVILLE: Mr. Ernest R. Gibson, Mr. Wm. Harold Parham, James E. Scatterday, D.V.M., and Mr. H. A. Schroder. MIAMI: Mr. John L. Rhodes and Colonel Oscar N. Taylor.

CHICAGO—A.M.A.: Thomas G. Hull, Ph. D., and Mr. Lawrence W. Rember.

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President's Report 1950

Though we have been geared to the fullest, and have worked ceaselessly since our last annual meeting, and though the tempo has enlivened and our crusade has steadily been gaining in momentum these past few months, we must pause long enough to turn the reins of leadership over to a fresh and enthused team of workers who will guide it through the ensuing year. Every doctor's wife is proud to say that she has had a part in this campaign for our inherent ideals of freedom and democracy and "Our American Way of Life."

Nothing has ever given me greater joy or strength of character than working shoulder to shoulder with you this year. We went back to our homes last April filled with enthusiasm and determination to fight for the ideals of the medical profession. Your wonderful reports will be the record that you have made, yet to be equaled, and I shall humbly present mine.

Within a few days after you had adopted the Resolution at Belleair, opposing Compulsory Health Insurance, copies with personal letters were mailed to the Governor and to every member of our State Legislature in session at that time. Within a week that body had passed a memorial to Congress strongly opposing Socialized Medicine in any form. Letters went to every Florida Congressman, Senator and to the President of the United States. The result of the landslide of correspondence and protest, coupled with that coming from the other 47 states to their members of Congress, kept the issue from coming up at the 80th Congress, and thus far at the 81st Congress.

Vigilance was kept throughout the year. Congratulatory letters were written to all 60 Senators who vetoed Mr. Truman's Reorganization Plan No. 1, the passing of which, in all probability, would have given Oscar Ewing a seat in the Cabinet. More than 300 personal letters went from

our Auxiliary to state and national legislators on the issue of Socialized Medicine. As your president, I was kept in constant touch with the A.M.A. office in Washington, acting immediately on any suggestion coming from them; with the National Education Campaign Headquarters in Chicago (having Miss Mary McGinn as our guest speaker at this convention indicates the close working harmony of this Auxiliary and their office); working in cooperation with our Florida headquarters and their Public Relations Chairmen.

It was my privilege to represent you at the A.M.A. Convention last June in Atlantic City where great stress was placed on Public Relations by A.M.A. and the National Auxiliary. The theme of Mrs. Allman's message bears repeating to you "Let us by every word, every deed, every act, place the facts before the public so that we will continue to merit the confidence placed in us by the A.M.A., so that we will truly be an Auxiliary in deeds as well as in name."

Our Fall Board Meeting was held in Jacksonville on October 5 in conjunction with the dedication of the Sellers Auditorium, the Duval County Medical Society's new club building. Six past presidents, all officers and chairmen except two and all county presidents or representatives except two attended. It was most enthusiastic. Drs. Payne and Killinger spoke at the Board Meeting, and Dr. Frank Slaughter at the luncheon, taking for his subject "What Every Doctor's Wife Should Know."

With the President-elect, Mrs. James L. Anderson, I attended the Fall Conference of State Presidents and National Chairmen in Chicago in November. We heard many outstanding speakers during the two-day session.

It was my privilege to attend the National Pharmaceutical Convention held in Jacksonville, the State Blue Cross and Blue Shield Banquet held there commemorating its fifth birthday; the State Education Campaign meeting, for which I sent notices to all officers, chairmen and county presidents. Your president spoke briefly at this meeting.

I was the speaker on Socialized Medicine at the Green Cove Springs Woman's Club at which time the club adopted a resolution opposing compulsory health insurance. I visited Ocala and aided them in reorganizing their Marion County Auxiliary; visited and spoke at the Auxiliary in Tallahassee, served on the official board of the

Heart Campaign assembling 1,000 hearts as my share of the county work; secured and introduced speakers for P.T.A. meetings on Socialized Medicine; wrote five articles for the Florida Medical Journal; wrote a summary of Florida's activities for the National Bulletin; wrote at least 1,000 letters and cards during my year as president; secured prominent and outstanding speakers for our present convention. For the first time in the history of its 76 years, your president with the national president, Mrs. David B. Allman, appeared and spoke briefly before the Open Session of the Florida Medical Association.

Due to the tremendous job I assumed as a doctor's wife, and not as your president, in the current senatorial crusade, I found it humanly impossible to visit all of the auxiliaries but endeavored in every other way possible to keep up the enthusiasm and all of the good work.

Auxiliary work has gone far this year, the Auxiliary itself receiving national recognition for its part in securing a Resolution here in Hollywood last May from the National Federation of Women's Clubs.

To each of you, I give praise and thanks for making all of these accomplishments possible. It was a pleasure and an honor to have served as your president. May we go forward with the new officers in the same zealous spirit and continuity of aims.

Respectfully,
Mrs. Chas. F. Henley

Dr. White's Address to Woman's Auxiliary

Madam President, members of the Woman's Auxiliary, and guests:

I appreciate very much the honor of appearing before your organization at its twenty-third annual meeting, and I bring to you greetings from the Florida Medical Association in its Seventy-Sixth annual convention.

Never before in the history of our organizations has the Woman's Auxiliary played such an important part, and never before have they been called upon to render aid to our profession in such a critical time. In the past year, through the official guidance of your president and other officers, you have been our main assistant in giving

information to the public concerning the threat of socialized medicine. The efforts of your labor are now bearing fruit, and I know you will be happy to hear that thirty-three other women's organizations throughout the state have passed resolutions opposing compulsory health insurance. These women's organizations extend from Key West to Fernandina, and from Apalachicola to Ft. Myers. It is indeed gratifying to know that not only the women of your Auxiliary, but also the women in general throughout the state, realize the threat of socialized medicine, and are supporting us in this fight. You will also be glad to hear that over four thousand various organizations throughout the county have, by resolution, gone on record as being opposed to governmental control of medical care. The battle has not yet been won, but, through your efforts, we have established a "beachhead," and are in a better position to fight the enemy.

From the time I was a young man and first became interested in medicine, I have heard the statement made by many doctors that "politics and medicine don't mix." Many doctors employ this statement to justify their failure to register and take an active part in the affairs of our country. Possibly, doctors have used this as another excuse for not taking any interest in the politics of their local community, because they were extremely busy people, or they did not care to get mixed up in local political issues. Because of the changing conditions of politics, this year of 1950 presents to all of us Florida doctors the fact that we must either enter the political arena, or see politics enter medicine!

Never before in the history of our state politics has the attention of the nation been so focused on the outcome of a senatorial race as in the present one; this race involves the question of compulsory versus voluntary health insurance, and embodies the future not only of the medical profession, but also of all the American people. It is imperative, therefore, that every one of us go to the polls on May second, and exercise our rights, as individual citizens, to vote and to help influence the political direction of our state and nation. Failure to do so this year may mean the ultimate termination of our traditional medical franchise — the right to practice medicine according to ethical professional and scientific standards — not political standards.

Read before the Twenty-Third Annual Meeting of the Woman's Auxiliary, Hollywood, April 25, 1950.

Index to Volume XXXVI

- Abresia of Rectum and Rectosigmoid, a Simultaneous Abdominal and Perineal Approach in Operations for Imperforate Anus (abst) 366
- Abscesses of Thigh and Intraperitoneal Air: Injuries to Right Thigh, Hip and Rectum Results of (abst) 495
- Acute Anterior Poliomyelitis: Case Report with Comments on Therapy (scientific) 98
- Acute Idiopathic Porphyria (abst) 698
- Adenoma, True, of Breast (scientific) 694
- Adrenal Cortical Tumor Associated with Cushing's Syndrome (abst) 494
- Age of Age (edit) 234
- Allergies, General, in Children (scientific) 287
- Allergic Subject, Eosinophilic Pleural Effusion and Pericarditis with Effusion in (abst) 430
- Allergy and Psychoneuroses (abst) 492
- Allergy to Penicillin, Observations on Variations in Reactivity in Case (abst) 493
- Aluminum Hydroxide Gel and Aureomycin (edit) 580
- Amebiasis, Surgical, Problems with Respect to Acute Appendicitis (scientific) 30
- American Academy of General Practice (commentary) 436
- American Dream or Nightmare (edit) 371
- American Druggist Surveys British State Medicine (edit) 298
- American Heart Association Research Awards (commentary) 167
- American Medical Association:
A. M. A. Clinical Session (commentary) 300
A. M. A. Washington Representative Visits Florida (commentary) 437
Annual Grass Roots Conference (commentary) 300
Convention Attendance (commentary) 106
Henderson, Dr. Elmer Lee, Honored in London (edit) 371
Henderson, Dr. Elmer Lee, President-Elect (edit) 104
House of Delegates Approves Separation of A. M. A. and A. M. C. P. (commentary) 168
Refraction Offer Investigated (commentary) 301
Report of Delegates to A. M. A. Convention (commentary) 302, 505
School Health Conference (commentary) 235
What Is the A. M. A.? (commentary) 302
- Amyloidosis in Rheumatoid Arthritis (abst) 368
- Amyloidosis, Study of Disappearance of Congo Red of Non-Amyloid Subjects and Patients (abst) 295
- Anesthesia, Cardiac Arrest Under (abst) 637
- Anesthetic Agent and Preanesthetic Medication (scientific) 32
- Annual Meeting, Seventy-Sixth (edit) 568, 579
- Anomalies, Congenital Eye Muscle (abst) 562
- Anorectal Surgery Complications (scientific) 488
- Antibody Response to Vaccination Against Murine Typhus (abst) 698
- Anuria and Oliguria Due to Sulfonamides; Prevention and Treatment (scientific) 360
- Anus, Imperforate, with Abresia of Rectum and Rectosigmoid; Simultaneous Abdominal and Perineal Approach in Operations (abst) 366
- Anxiety States, Insulin Sub-Shock in Treatment (abst) 566
- Appendicitis, Acute, Problem of Surgical Amebiasis (scientific) 30
- Appendicitis in the Aged: A Report of Five Cases (scientific) 634
- Arthritis, Rheumatoid, Amyloidosis in (abst) 368
- Articulation, Lumbosacral (abst) 495
- Atrioventricular Canal with Patent Interatrial Foramen Primum, Incomplete Division of (abst) 564
- Aureomycin and Aluminum Hydroxide Gel (edit) 580
- Autohemetic Therapy, Modified (scientific) 22
- Back, Low-Fused, Early Ambulation (scientific) 211
- Barbiturate Poisoning, Acute, with PicROTOXIN and Metrazol; Treatment (abst) 492
- Basal Metabolic Rate in Diagnosis (abst) 228
- Better Public Relations (edit) 778
- Bilateral Laryngeal Paralysis (scientific) 692
- Blood Bank, New Building (commentary) 582
- Blue Cross Plan, Florida's Fifth Anniversary; Dr. Hawley Speaks (commentary) 164
- Blue Shield:
A. M. A. House of Delegates Approves Separation of A. M. A. and A. M. C. P. (commentary) 168
Additional Benefit 41
Annual Meetings 40, 582, 783
Blue Shield Reminders 375
Close Affiliation with Blue Cross 236
Election of Officers 41
Facts About Blue Cross-Blue Shield Series "7" Contract Availability 509
Facts About Blue Shield Emergency Service 704
New Blue Shield-Blue Cross Contracts 437
Payment of Blue Shield Cases 308
Reports of President and Executive Director 41
Thank You, Doctor 646
- Books Received:
A. M. A.: New and Nonofficial Remedies, 1949 176
A. M. A.: Reviews of Medical Motion Pictures and List of Films Available Through the Motion Picture Library, American Medical Association 49
Bailey, H.: The Physiology of Thought, a Functional Study of the Human Mind in Action 592
Beck, L. F.: Human Growth, Story of How Life Begins and Goes On 592
Boland, Frank Kells, M.D.: The First Anesthetic, the Story of Crawford Long, 1950 803
Commission on Chronic Illness 803
Commission on Chronic Illness, Proceedings of First Meeting 803
Committee for the Golden Jubilee Tribute to Dr. Sidney V. Haas: Golden Jubilee World Tribute to Dr. Sidney V. Haas 520
Conason, Emil G., M.D., and Metz, Ella: The Salt-Free Diet Cook Book, 1949 658
Davison, W. C.: The Compleat Pediatrician, Practical, Diagnostic, Therapeutic and Preventive Pediatrics 519
de Kruif, P.: Life Among the Doctors 519
Goodale, R. H.: Clinical Interpretation of Laboratory Tests 447
Gordon, B. L.: Medicine Throughout Antiquity 176
Jones, H. W., Hoerr, N. L., and Osol, A.: Blakiston's New Gould Medical Dictionary 318
Merritt, W.: Century of Medicine in Jacksonville and Duval County, 1949 112
Moon, G. R.: How to Become a Doctor 176
Neffson, A. H.: Acute Laryngotracheobronchitis 520
Progress in Neurology and Psychiatry, an Annual Review, 1949 658
Saltzman, M.: Clinical Audiology 447
Shapiro, Shepard, M.D., and Weiner, Murray, B. S., M.S., M.D.: Coagulation, Thrombosis, and Dicumarol with an Appendix on Related Laboratory Procedures 803
Tobin, C. E.: Shearer's Manual of Human Dissection 318
World Health Organization: International Digest of Health Legislation 177
- Breast, Cancer: Comparison Study of Findings in Charity Clinic and in Private Clinic (scientific) 143
- Brief Stimulus Convulsive Therapy (scientific) 25
- Britain's Health Program Presented at University of Florida (edit) 434
- British Opinions on Socialization of Medicine (edit) 163
- Burn Areas, Early Closure (scientific) 149
- Cancer of Breast: Comparison Study of Findings in Charity Clinic and in Private Clinic (scientific) 143
- Cancer Seminar (commentary) 504
- Cancer of Skin in Florida (scientific) 619
- Carcinoma of Breast: Role of Irradiation in Management (abst) 295
- Carcinoma of Ureter; Report of Three Cases (abst) 565
- Cardiac Arrest Under Anesthesia (abst) 637

(Continued on page 791)



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Cardiovascular Disease; Negative Results of Tocolpherol Therapy (abst).....	499
Carotid Sinus Syncope (abst).....	636
Carotid Sinus Syndrome (abst).....	367
Changes in the Electrocardiogram in Toxic States (scientific).....	687
Church Group Decries Socialized Medicine (edit).....	105
Chronic Illness, Nation's Daily Disaster (edit).....	299
Chronic Intestinal Intussusception in the Adult (abst).....	431
Chronic Secretory Otitis (abst).....	431
Circus (scientific).....	411
Cirrhosis, Some Comments on Portal (abst).....	636
Clinical Application of Electrocardiography (scientific).....	420
Clinical Medicine; Practical Value of Liver Function Tests (abst).....	562
Clinical Response to Crowe's Vaccine in 125 Cases of Rheumatic Disease (scientific).....	290
Clinical Session of A. M. A. (commentary).....	300
Coccygodynia: Report of One Hundred and Fifty Cases (scientific).....	27
Combined Extrauterine and Intrauterine Pregnancy (abst).....	493
Comments on Diverticula of Gastrointestinal Tract (scientific).....	415
Community Health, For Better (edit).....	372
Complete Dislocation of Talus (abst).....	368
Complications of Anorectal Surgery (scientific).....	488
Compulsory Health Insurance:	
American Druggist Surveys British State Medicine (edit).....	298
Britain's Health Program Presented at University of Florida (edit).....	434
British Opinions on Socialization of Medicine (edit).....	163
Church Group Decries Socialized Medicine (edit).....	105
Health Legislation Before Eighty-First Congress (commentary).....	167
In One Door and Out the Other (edit).....	502
Make It Real (edit).....	233
Results of Letters to Congressmen (Woman's Auxiliary).....	243
Socialized Medicine Preview (commentary).....	642
"Something for Nothing" Boomerang (edit).....	162
Those Selfish Doctors (edit).....	503
Truman's Wonderland (edit).....	640
Utopia on the Rocks (edit).....	231
Whither Would You Flee? (edit).....	298
Congenital Extrinsic Duodenal Obstruction in the New Born: Report of Two Cases (abst).....	227
Congenital Eye Muscle Anomalies (abst).....	562
Congestive Heart Failure: Current Concepts in Therapy (scientific).....	624
Congo Red from Blood of Non-Amyloid Subjects and Patients with Amyloidosis; Study of Disappearance (abst).....	295
Contribution to the History of Medicine in Florida (edit).....	103
Convulsive Therapy, Brief Stimulus (scientific).....	25
Convulsive Therapy and Involutional Melancholia (abst).....	496
Coronary Insufficiency; Master Two Step Exercise Test in Diagnosis (scientific).....	275
Crowe's Vaccine; Clinical Response in 125 Cases of Rheumatic Disease (scientific).....	290
Curare Induction for Endotracheal Intubation, Pentobarbital Sodium (abst).....	227
Current Concepts in Therapy of Congestive Heart Failure (scientific).....	624
Cushing's Syndrome; Associated with Adrenal Cortical Tumor (abst).....	494
Cutaneous Testing and Untoward Reactions in Penicillin Therapy (abst).....	429
Cyst Formation in Old Hematoma; Sciatica Caused by (abst).....	637

Deaths:

Members:

Black, Nelson M., Jr., Coconut Grove	110, 172
Bradshaw, John T., San Antonio	42, 112
Brinson, William D., Baldwin	782

(Continued on page 792)



From where I sit
by Joe Marsh

His Punch is His Signature

Was on the train up to Central City the other day and when the conductor came around, I asked him why their ticket punches make such odd-shaped holes in the ticket.

"Every conductor in the country has a different design for his punch," he tells me. "Some even show up a fellow's preferences. Now take mine. The hole looks like a beer goblet."

Sure enough! Then he went on to say that the punch is just like the conductor's personal signature. Makes it easy to trace tickets . . . to check up if something happens.

From where I sit, even though your ticket is punched differently from mine, it still gets you where you're going. Just like people with their opinions. You might like coffee, another person, tea—and I'll settle for a temperate glass of beer. But what does it matter, so long as we respect the *right* of the other to have tastes and opinions? We're all trying to go in the same direction—towards a friendlier, more pleasant world for all of us.

Joe Marsh

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Kinsey, E. Thomas, Madison	237, 312
Lott, Young C., Miami	309, 383
McGinnis, Robert H., Jacksonville	509, 650
Marshall, Louis R., Jacksonville	377, 440
Neal, Thomas A., Orlando	169, 171
Ney, Karl W., Stuart	110, 238
O'Quinn, Leon H., Hialeah	509, 653
Oshlag, Julius A., Miami Beach	438, 514
Perry, C. Larrimore, Miami	169, 239
Pintado, Nilo C., Miami	169, 240
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Slaughter, Thomas K., Wildwood	237, 240
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Other Doctors:	
Adams, Dallas H., Milton	705
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Babcock, Donald T., Los Angeles, Calif.	583
Brann, Harold W., Palo Alto, Calif.	237
Butchart, Thomas R., Tampa	782
Davis, Claude L., Alma, Ga.	42
DeVane, William G., Groveland	583
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Erwin, Archie L., Nashville, Tenn.	377
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Friedbacher, Karl, West Allis, Pa.	42
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Griffith, Daniel H., Frostproof	237
Hardie, Dan, Miami	309
Longbrake, Guy A., Ft. Myers	237
McCormick, Wm. M., Falls Creek, Pa.	42
McQueen, Archibald B., St. Petersburg	42
Martin, Irl E., Ocklawaha	377
Moore, Alfred, Memphis, Tenn.	705
Murphy, Hugh K., Mulberry	705
Myers, Edward L., Woonsocket, R. I.	583
Nichols, Stanley H., Asbury Park, N. J.	583
Perkins, Franklin A., Boston, Mass.	237
Philpot, Irvin P., Branford	42
Roper, Luther E., Hollywood	705
Thomas, William H., Jacksonville	110
Von Dahm, Howard C., Lake City	42
Williams, Forrest E., Pacific Grove, Calif.	42
Wilson, Siver A., Bradenton	169
Democracy, New Meaning (edit)	581
Demonstration of Sinus Tracts, Fistulas and Infected Cavities by Lipiodol (abst)	563
Dermatitis Due to Wearing Apparel (scientific)	551
Dermatitis, Industrial, in Florida (scientific)	223
Diabetes Detection Drive Progresses (commentary)	167
Diabetes Mellitus: Practical Management of Ambulatory Cases (abst)	500
Diagnosis and Early Treatment of Poliomyelitis (scientific)	225
Diagnosis and Treatment of Infertility (scientific)	219
Diagnosis of the Commoner Hemorrhagic Diseases (scientific)	280
Diarrheal Diseases, Acute: Studies (4 articles) (abst)	497
Digitoxin, Observations on (scientific)	629

Dislocated Disc of Lumbar Region (abst)	366
Diverticula of Gastrointestinal Tract: Comments (scientific)	415
Doctors Are Citizens (commentary)	703
Drugs, New (scientific)	157
Duodenal Obstruction, Congenital Extrinsic, in the New Born (abst)	227
Duval County Medical Society New Auditorium Opened (commentary)	300
Duval Monthly Bulletin, Revised (commentary)	644
Early Ambulation of Low-Fused Back (scientific)	211
Early Closure of Burn Areas (scientific)	149
Education Campaign Materials (commentary)	107
Eighteenth Annual Graduate Short Course (commentary)	779
Electrocardiogram Changes in Toxic States (scientific)	687
Electrocardiography: Clinical Application (scientific)	420
Emboli, Multiple Arterial (abst)	565
Endocrinology Postgraduate Assembly (commentary)	503
Endotracheal Intubation, Pentobarbital Sodium—Curare Induction (abst)	227
Eosinophilic Pleural Effusion and Pericarditis with Effusion in an Allergic Subject (abst)	430
Epidemic, 1949, of Investigations, F.M.A. Headquarters Visited (edit)	436
Epiphysis, Slipped, in Adolescent Hip: Reconsideration of Open Reduction (abst)	160
Erythrocytes from Persons with Sickle Cell Disease; Viscosity Studies (abst)	499
Evaluation of 354 Consecutive Hysterectomies Performed at Orange Memorial Hospital (abst)	430
Extrauterine Pregnancies; Fate of Living Viable Babies (abst)	492
Ewing's Heap of Beans (edit)	702
Failure of Urogenital Union (abst)	496
Fate of Living Viable Babies in Extrauterine Pregnancies (abst)	492
Fenestration Operation (abst)	697
Fibrolipomatous Nodules Simulating Uretero-Renal Disease; Somatic Pain Due to (abst)	565
Fifth Anniversary of Florida's Blue Cross Plan: Dr. Hawley Speaks (commentary)	164
Fistulas and Infected Cavities by Lipiodol; Demonstration of Sinus Tracts (abst)	563
Flight Through Space (edit)	701
Florida Legislature (E. G. Peek) (commentary)	307
For Better Community Health (edit)	372
Foreign Medical Graduates, Problems of Licensure (edit)	37
General Allergies in Children (scientific)	287
General Practitioner Today (scientific)	95
Goiter, Intrathoracic (scientific)	154
Graduate Courses Held (commentary)	106
Graduate Instruction in Serodiagnosis and Treatment of Syphilis (commentary)	40
Graduate Medical Education Schedule (commentary)	504
Granuloma Inguinale; Streptomycin Therapy (scientific)	355
Grass Roots, Annual, Conference (commentary)	300
Guest Speaker, Alton Ochsner, M.D.	578
Harris, Seale, Honored (edit)	105
Health Legislation Before Eighty-First Congress (commentary)	167
Heart Disease: Clinical Evaluation (scientific)	83
Hematoma; Sciatica Caused by Cyst Formation (abst)	637
Hematomas of Parturient Canal (abst)	563
Hematuria: Clinical Significance (scientific)	86
Hemorrhage, Postpartum, in Prolonged Labor (abst)	697
Hemorrhagic Diseases, Commoner: Diagnosis (scientific)	280
Henderson, Elmer Lee, Honored in London (edit)	371
Henderson, Elmer Lee, President-Elect of the A.M.A. (edit)	104
Hermaphroditism, True; Endocrine Studies in Case of Ootestis (abst)	159

(Continued on page 794)

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History of Medicine in Florida, Contribution to (edit)	103
Hollywood-by-the-Sea	567
Hookworm Disease, Mistaken Surgical Diagnoses (abst)	159
Hoover Commission Report; Better Government at Lower Cost (edit)	36
How Embarrassing (commentary)	703
Hygeia, New Name for (commentary)	581
Hyperparathyroidism, Primary Hypertrophy and Hyperplasia of Parathyroid Glands as Cause (abst)	159
Hyperplasia and Primary Hypertrophy of Parathyroid Glands as Cause of Hyperparathyroidism (abst)	159
Hyperprothrombinemia Induced by Vitamin K in Human Subjects with Normal Liver Function (abst)	296
Hypertension, Influence of Supradiaphragmatic Splanchnicectomy on Heart (abst)	431
Hypertension, Prepregnant, Treated by Splanchnicectomy Toxemia Superimposed upon (abst)	499
Hypertensive Disease of Pregnancy Treated by Splanchnicectomy (abst)	697
Hysterectomies Performed at Orange Memorial Hospital, and Evaluation of 354 Consecutive (abst)	430
Immediate Urticarial Reaction to Intradermal Testing in Penicillin Hypersensitivity (abst)	493
Incomplete Division of Atrioventricular Canal with Patent Interatrial Foramen Primum (abst)	564
Industrial Dermatitis in Florida (scientific)	223
Infertility: Diagnosis and Treatment (scientific)	219
Influence of Supradiaphragmatic Splanchnicectomy on Heart in Hypertension (abst)	431
Information Medical Reserve Officers (commentary)	644
Injuries to Right Thigh, Hip and Rectum, Resulting in Intraperitoneal Air and Abscesses of Thigh (abst)	495
In One Door and Out the Other (edit)	502
Insulin Sub-Shock in the Treatment of Anxiety States (abst)	566
Intern Association Linked to Reds (commentary)	643
Intradermal Testing in Penicillin Hypersensitivity: Immediate Urticarial Reaction (abst)	493
Intraperitoneal Air and Abscesses on Thigh: Results of Injuries to Right Thigh, Hip and Rectum (abst)	495
Intrathoracic Goiter (scientific)	154
Intussusception in the Adult, Chronic Intestinal (abst)	431
Investigations (Federal), 1949 Epidemic; Headquarters Visited (edit)	436
Involuntary Melancholia and Convulsive Therapy (abst)	496
Irradiation in Management of Carcinoma of Breast (abst)	295
Irradiation Ulcers, Late: Use of Radon Ointment in Treatment (abst)	294
Labeling Requirements for Prescriptions (edit)	778
Labor, Prolonged, with Special Reference to Postpartum Hemorrhage (abst)	697
Laws Enacted, 1949 (commentary)	307
Lay Comments on Socialized Medicine (commentary)	704
Legislature, Florida (commentary)	307
Let's Be Ready for the Next Round (edit)	234
Licensure of Foreign Medical Graduates, Problems (edit)	37
Lipiodol; Demonstration of Sinus Tracts, Fistulas and Infected Cavities (abst)	563
Liver Function, Normal; Hyperprothrombinemia by Vitamin K in Human Subjects (abst)	296
Liver Function Tests in Clinical Medicine; Practical Value (abst)	562
Logic and Democracy Not Incompatible (edit)	642
Longevity (Age of Age) (edit)	234
Lumbar Region, Dislocated Disc (abst)	366
Lumbosacral Articulation (abst)	495
Lymphoid Eustachian Salpingitis (abst)	493
Make It Real (edit)	233
Malignant Hypertension and Its Treatment by Splanchnic Resection (abst)	496
Master Two Step Exercise Test in the Diagnosis of Coronary Insufficiency (scientific)	275
Maternal Mortality: United States, 1947 (commen-	

tary)	39
Meaning of Democracy (edit)	581
Measurement of Sensation (abst)	638
Medical District Meetings, 1949 (commentary)	372
Medical District Meetings	85, 100, 235, 372
Medical Golf Tournament (commentary)	778
Medical Licenses Granted	311, 645
Medical Officers Returned	238, 310, 379
Meetings:	
American Academy of General Practice (commentary)	436
A.M.A. Clinical Session (commentary)	300
A.M.A. Convention, 1949 (commentary)	106
A.M.A. School Health Conference (commentary)	235
Annual Grass Roots Conference (commentary)	300
Graduate Courses Held (commentary)	106
Medical District Meetings	372
Midwinter Meeting of Florida Society of Ophthalmology and Otolaryngology (commentary)	643
Midwinter Seminar in Ophthalmology and Otolaryngology (commentary)	642
Postgraduate Assembly in Endocrinology (commentary)	503
Rural Health Conference (commentary)	436
Seminar on Cancer (commentary)	504
Seminar on Tuberculosis (commentary)	644
Seventy-Sixth Annual Meeting (edit)	568, 579
Melancholia, Involuntal, and Convulsive Therapy (abst)	496
Mellitus, Diabetes: Practical Management of Ambulatory Cases (abst)	500
Members, New 44, 111, 170, 238, 312, 379, 511, 646,	705
Metrazol and Picrotoxin in Treatment of Acute Barbiturate Poisoning (abst)	492
Midwinter Meeting of Florida Society of Ophthalmology and Otolaryngology (commentary)	643
Midwinter Seminar in Ophthalmology and Otolaryngology (commentary)	642
Mistaken Surgical Diagnoses in Hookworm Disease (abst)	159
Modern Concepts in Prevention and Treatment of Puerperal Infection (scientific)	215
Modified Autohemetic Therapy (scientific)	22
Modified Irrigating Solution for Transurethral Prostatic Resections: Preliminary Report (abst)	227
More About Naturopaths and Naturopathy (edit)	102
Morphine Withdrawal Syndrome; Pyribenzamine as Adjunct in Control (abst)	367
Multifocal Malignant Neoplasia (scientific)	484
Multiple Arterial Emboli (abst)	565
Multiple Cystic Tuberculosis of the Bones (abst)	500
Murine Typhus, Antibody Response to Vaccination (abst)	698
Nasal Sinusitis: Evaluation of Sulfonamides and Penicillin in Its Treatment (abst)	494
National Education Campaign	42, 110, 169, 236, 309, 376, 704
Nation's Daily Disaster (edit)	299
Naturopaths and Naturopathy (edit)	102
Necrosis of the Ureter Following the Wertheim Operation, Study of Ureteral Blood Supply and its Bearing on (abst)	295
Negative Results of Tocopherol Therapy in Cardiovascular Disease (abst)	499
Neoplasia, Multifocal Malignant (scientific)	484
New Born, Congenital Extrinsic Duodenal Obstruction; Report of 2 Cases (abst)	227
New Building for Jacksonville Blood Bank (commentary)	582
New Drugs (scientific)	157
New Name for Hygeia (commentary)	581
Nineteen Fifties (edit)	641
Nonmalignant Diseases Treated with Radiation, What May be Expected (scientific)	19
Notice to Delegates and Committee Chairmen (edit)	580
Nutritional Appraisal of School Children (scientific)	632

(Continued on page 796)

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Observations on Digitoxin (scientific)	629
Observations on Variations in Reactivity in Case of Allergy to Penicillin (abst)	493
Ochsner, Alton, M.D., Guest Speaker	578
Oliguria and Anuria due to Sulfonamides; Prevention and Treatment (scientific)	360
Ophthalmology and Otolaryngology, Midwinter Meeting of Florida Society (commentary)	643
Ophthalmology and Otolaryngology, Midwinter Seminar (commentary)	642
Ophthalmology and Otolaryngology (Dr. Palmer's Message) (commentary)	39
Osler, Sir William (edit)	370
Otitis, Chronic Secretory (abst)	431
Ovotestis, Endocrine Studies in Case of; True Hermaphroditism (abst)	159
Palmer's, Dr., Message (commentary)	39
Pan American Ophthalmology-Antiblindness Meeting (commentary)	779
Paralysis, Bilateral Laryngeal (scientific)	632
Paralysis, Tick: Report of a Case from Florida (scientific)	561
Parathyroid Glands, Primary Hypertrophy and Hyperplasia of; as Cause of Hyperparathyroidism (abst)	159
Participation in Politics Clarified (commentary)	582
Parturient Canal Hematomas (abst)	563
Peace of Mind (edit)	371
Pediatric Proctology (abst)	499
Pediatrics: Changing Concepts and Responsibilities in Practice (abst)	367
Pediatrics: Current Trends in Practice and Training (scientific)	351
Peek, Eugene G.; Florida Legislature (commentary)	307
Penicillin Allergy, Observations on Variations in Reactivity (abst)	493
Penicillin Hypersensitivity, Immediate Urticarial Reaction to Intradermal Testing (abst)	493
Penicillin; Quantitative Serologic Titer in Post-Treatment Observation of Early Syphilis (abst)	638
Penicillin Rivals Forge Ahead (edit)	232
Penicillin and Sulfonamides, Evaluation of Treatment of Nasal Sinusitis (abst)	494
Penicillin Therapy; Untoward Reactions and Cutaneous Testing (abst)	429
Pentobarbital Sodium—Curare Induction for Endotracheal Intubation (abst)	227
Pericarditis with Effusion and Eosinophilic Pleural Effusion in an Allergic Subject (abst)	430
Physician Looks at His Government (edit)	700
Picrotoxin and Metrazol in Treatment of Acute Barbiturate Poisoning (abst)	492
Pinnell's Mail Bag (commentary)	644
Pleural Effusion, Eosinophilic, and Pericarditis with Effusion in an Allergic Subject (abst)	430
Policy of State Board of Health in Dealing with Medical Profession (commentary)	109
Poliomyelitis, Acute Anterior: Case Report with Comments on Therapy (scientific)	98
Poliomyelitis, Diagnosis and Early Treatment (scientific)	225
Poliomyelitis; Tick Paralysis May Simulate (commentary)	109
Politics Clarified, Participation in (commentary)	582
Porphyria, Acute Idiopathic (abst)	698
Postgraduate Assembly in Endocrinology (commentary)	503
Practical Value of Liver Function Tests in Clinical Medicine (abst)	562
Preanesthetic Medication and Choice of Anesthetic Agent (scientific)	32
Pregnancies, Extrauterine, Fate of Living Viable Babies (abst)	492
Pregnancy, Combined Extrauterine and Intrauterine (abst)	493
President's Address, Walter C. Payne, M.D.	739
Prevention and Treatment of Oliguria and Anuria due to Sulfonamides (scientific)	360

(Continued on page 798)



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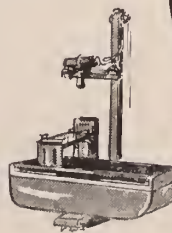
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Preview, 1950 (edit)	435	Registration, Annual Meeting	772
Primary Hypertrophy and Hyperplasia of Parathyroid Glands as Cause of Hyperparathyroidism (abst) ..	159	Relativity of Health (edit)	702
Problem of Malignant Hypertension and Its Treatment by Splanchnic Resection (abst)	496	Reliability of Serologic Examinations as Performed in Medical Laboratories in Florida (scientific)	427
Problem of Surgical Amebiasis with Respect to Acute Appendicitis (scientific)	30	Remarks on Surgery of Sympathetic Nervous System (scientific)	90
Problems of Licensure of Foreign Medical Graduates (edit)	37	Reorganization Plan:	
Proceedings, Seventy-Sixth Annual Meeting	744	Hoover Commission Report; Better Government at Lower Cost (edit)	36
Proctology, Pediatric (abst)	499	Let's Be Ready for the Next Round (edit)	234
Program of the Seventy-Sixth Annual Meeting	568	Results of Letters to Congressmen (Woman's Auxiliary)	243
Progress at Annual Meeting (edit)	777	Truman Loses, Medicine Wins Battle (edit)	230
Progress in Tuberculosis Control in Florida (scientific) ..	547	Report of Delegates to A.M.A. Convention (commentary)	302, 505
Prolonged Labor, with special Reference to Postpartum Hemorrhage (abst)	697	Reserve Officers, Medical, Information (commentary)	644
Prostatic Resections, Transurethral, Modified Irrigating Solution (abst)	227	Revised Duval Monthly Bulletin (commentary)	644
Prothrombin Response to the Parenteral Administration of Large Doses of Vitamin K (abst)	296	Rheumatic Disease, Clinical Response to Crowe's Vaccine in 125 Cases (scientific)	290
Psychoneuroses and Allergy (abst)	492	Rheumatoid Arthritis, Amyloidosis (abst)	368
Psychosomatic Medicine (Peace of Mind) (edit)	371	Rice Diet (edit)	502
Puerperal Infection, Modern Concepts in Prevention and Treatment (scientific)	215	Roentgen Manifestations in the Skull of Metastatic Carotid Body Tumor (Paraganglioma), of Meningioma and of Mucocele (abst)	294
Pulmonary Diseases: a Critique, Role of the X-Ray in Diagnosis (scientific)	554	Role of Irradiation in Management of Carcinoma of Breast (abst)	295
Purpose, Supreme, of a Profession (edit)	580	Role of Roentgen Ray in Diagnosis of Pulmonary Diseases: a Critique (scientific)	554
Pyribenzamine as Adjunct in Control of Morphine Withdrawal Syndrome (abst)	367	Rural Health Conference (commentary)	436
Pyuria; Study of One Hundred Cases (scientific)	475	Salpingitis, Lymphoid Eustachian (abst)	493
Quantitative Serologic Titer in Post-Treatment Observation of Early Syphilis Treated with Penicillin (abst)	638	Schedule of Short Course	780
Radiation Treatment of Nonmalignant Diseases, What May Be Expected (scientific)	19	Sciatica Caused by Cyst Formation in Old Hematoma (abst)	637
Radon Ointment in Treatment of Late Irradiation Ulcers (abst)	294	Scientific Assemblies	771
Refraction Offer Investigated (commentary)	301	Selfish Doctors, Those (edit)	503
		Sellers Auditorium (Duval County Society New Auditorium) (commentary)	300
		Seminary on Cancer (commentary)	504
		Seminar on Tuberculosis (commentary)	644
		Sensation Measurement (abst)	638

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Serologic Examinations as Performed in Medical Laboratories in Florida (scientific).....	427
Seventy-Sixth Annual Meeting (edit)	568, 579
Seventy-Sixth Annual Meeting A Great Success (edit)	777
Sickle Cell Disease, Viscosity Studies of Erythrocytes from Persons with (abst)	499
Simultaneous Abdominal and Perineal Approach in Operations for Imperforate Anus with Abresia of Rectum and Rectosigmoid (abst).....	366
Sinus Tracts, Fistulas and Infected Cavities by Lipiodol, Demonstration of (abst).....	563
Sinusitis Nasal: Evaluation of Sulfonamides and Penicillin in Its Treatment (abst)	494
Sir William Osler (edit)	370
Slipped Epiphysis in Adolescent Hip: Reconsideration of Open Reduction (abst)	160
Smith, Dr. Austin (edit)	640
Socialization of Medicine, British Opinions (edit)	163
Socialized Medicine Preview (commentary)	642
Somatic Pain Due to Fibrolipomatous Nodules Simulating Uretero-Renal Disease (abst)	565
Some Aspects of Hypertensive Disease of Pregnancy Treated by Splanchnicectomy (abst).....	697
Some Comments on Portal Cirrhosis (abst).....	636
Something for Nothing Boomerang (edit).....	162
Splanchnic Resection; Problem of Malignant Hypertension and Its Treatment (abst)	496
Splanchnicectomy on Heart in Hypertension; Influence of Supradiaphragmatic (abst).....	431
Splanchnicectomy in Treatment of Hypertensive Disease of Pregnancy (abst).....	697
State Board of Health, Policy in Dealing with Medical Profession (commentary).....	109
Streptomycin Therapy in Granuloma Inguinale (scientific)	355

Studies in Acute Diarrheal Diseases (4 articles) (abst)	497
Study of Disappearance of Congo Red from Blood of Non-Amyloid Subjects and Patients with Amyloidosis (abst).....	295
Study of Ureteral Blood Supply and Its Bearing on Necrosis of Ureter Following Wertheim Operation (abst)	295
Sulfonamides and Penicillin; Evaluation of Treatment of Nasal Sinusitis (abst)	494
Supreme Purpose of a Profession (edit).....	580
Surgery, Anorectal, Complications (scientific).....	488
Sympathetic Nervous System, Remarks on Surgery (scientific)	90
Syncope, Carotid Sinus (abst).....	636
Syndrome, Carotid Sinus (abst).....	367
Syphilis, Early, Treated with Penicillin; Quantitative Serologic Titer in Post-Treatment Observation (abst)	638
Syphilis Treatment and Serodiagnosis Graduate Instruction (commentary).....	40
Talus, Complete Dislocation (abst).....	368
Technical Exhibit	586
Television in Medical Education (edit).....	778
Tetraethylpyrophosphate, Toxic Effects (scientific)	417
Tick Paralysis May Simulate Poliomyelitis (commentary)	109
Tick Paralysis, Report of a Case from Florida (scientific)	561
Tocopherol Therapy in Cardiovascular Disease, Negative Results (abst).....	499
Toxemia Superimposed upon Prepregnant Hypertension Treated by Splanchnicectomy (abst).....	499
Toxic Effects of Tetraethylpyrophosphate (scientific)	417
Treatment of Acute Barbiturate Poisoning with Picrotoxin and Metrazol (abst)	492

(Continued on page 800)

Treatment of Trichomonas Vaginalis with Tyrothricin (abst)	495	Their Treatment (abst)	563
Trichomonas Vaginalis with Tyrothricin Treatment (abst)	495	Venereal Granulomas: Comparative Study of These Diseases in Florida (abst)	227
True Adenoma of Breast (scientific)	694	Viscosity Studies of Erythrocytes from Persons with Sickle Cell Disease (abst)	499
True Hermaphroditism; Endocrine Studies in Case of Ovotestis (abst)	159	Vitamin K in Human Subjects with Normal Liver Function, Hyperprothrombinemia Induced by (abst)	296
Truman Loses, Medicine Wins Battle on Reorganization Plan (edit)	230	Vitamin K, Prothrombin Response to Parenteral Administration of Large Doses (abst)	296
Truman's Wonderland (edit)	640	Vitamin K Tolerance Test (abst)	429
Tuberculosis of the Bones, Multiple Cystic (abst)	500	Wertheim Operation; Study of Ureteral Blood Supply and Its Bearing on Necrosis of Ureter (abst)	295
Tuberculosis Control Progress in Florida (scientific)	547	What Is the A.M.A.? (commentary)	302
Tuberculosis Seminar (commentary)	644	What May Be Expected of Radiation Treatment of Nonmalignant Diseases (scientific)	19
Tumor, Adrenal Cortical, Associated with Cushing's Syndrome (abst)	494	White, Herbert E., M.D., President	776
Tumors, Vascular, of Brain and Spinal Cord and Their Treatment (abst)	563	Whither Would You Flee? (edit)	298
Tyrothricin Treatment of Trichomonas Vaginalis (abst)	495	Woman's Auxiliary:	
Ulcers, Late Irradiation; Use of Radon Ointment in Treatment (abst)	294	Annual Meeting of Southern Auxiliary	517
Untoward Reactions and Cutaneous Testing in Penicillin Therapy (abst)	429	Convention Highlights	656
Ureter Carcinoma: Report of Three Cases (abst)	565	Highlights of the National Fall Conference	445
Uretero-Renal Disease, Somatic Pain Due to Fibrolipomatous Nodules Simulating (abst)	565	National Education Campaign	46
Urinary Incontinence in the Female, Urologic Consideration (scientific)	479	Organization	317, 384
Urogenital Union Failure (abst)	496	President's Report	786
Urologic Consideration of Urinary Incontinence in the Female (scientific)	479	Public Relations Chairman Speaks	172
Urticarial Reaction, Immediate, to Intradermal Testing in Penicillin Hypersensitivity (abst)	493	Results of Letters to Congressmen on Compulsory Health Insurance	243
Use of Radon Ointment in Treatment of Late Irradiation Ulcers (abst)	294	White's, Dr., Address	787
Utopia on the Rocks (edit)	231	Wonderful Warriors; Doctors' Wives (edit)	37
Vascular Tumors of the Brain and Spinal Cord and		X-Ray Role in Diagnosis of Pulmonary Diseases: a Critique (scientific)	554

Index to Authors

Articles	
Anderson, Egbert V., Pensacola	561
Bandler, Clarence G., New York City	86
Batsche, Joseph H., Melbourne	355
Birchall, Robert, New Orleans	360

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Butt, Arthur J., Pensacola	360, 479	Quillian, Warren W., Coral Gables	351
Carron, Harold, Tampa	32	Raap, Gerard, Miami	415
Dyrenforth, Lucien Y., Jacksonville	484	Reed, Francis A., Miami Beach	420
Ellingson, Oren A., Tampa	219	Reiss, Jack, Miami Beach	554
Farrior, J. Brown, Tampa	692	Robins, R. B., Camden, Ark.	95
Folsom, Spencer A., Orlando	83	Sharp, Clarence M., Jacksonville	547
Frehling, Stanley, Miami	694	Smith, Tom E., Dallas, Tex.	488
Friedewald, William F., Atlanta, Ga.	225	Sondag, Roger F., Jacksonville	355
Fuller, Henry, Lakeland	629	Straight, William M., Miami	624
Halton, Joseph, Sarasota	411	Swink, Robert L., Miami	694
Hanson, Karl B., Jacksonville	275	Taylor, Gordon B., St. Petersburg	551
Hardy, Albert V., Jacksonville	427	White, Alvyn W., Pensacola	561
Henry, Jimmy F., Winter Haven	355	Wilkins, Walter, Jacksonville	632
Herz, Ralph, Key West	634	Wilson, Wesley W., Tampa	619
Izlar, William H., Miami	98	Wright, John E., Miami	98
Jelks, Edward, Jacksonville	143	Zellner, Robert E., Orlando	154
Jewett, Eugene L., Orlando	211		
Johnson, Garland M., Ft. Lauderdale	417	Abstracts	
Kelley, William H., Orlando	83	Bedell, Sullivan G., Jacksonville	566
Kennedy, Alpheus T., Jacksonville	143, 484	Bowen, Frederick H., Jacksonville	495
Kittredge, W. E., New Orleans, La.	479	Bowen, Jack H., Jacksonville	638
Kovnat, Maurice, Miami Beach	554	Brooks, William H., Jacksonville	565
Lipscomb, Thomas H., Jacksonville	19	Butt, Thomas C., Orlando	565
Lisenby, Amsie, H., Panama City	30	Carron, Harold, Tampa	227
Lyerly, James G., Jacksonville	90	Collins, Chas. J., Orlando	430
McCollough, Newton C., Orlando	211	Dell, J. Maxey, Jr., Gainesville	563
McDonald, John M., Jacksonville	223	Donegan, Charles K., St. Petersburg	499
McEwan, Duncan T., Orlando	154	Douglas, Joseph W., Pensacola	159, 495
Maguire, Charlotte C., Orlando	287	Economon, James G., Orlando	159
Mason, Michael L., Chicago, Ill.	149	Evans, Elwyn, Orlando	367, 636
Mease, John A., Jr., Dunedin	22	Farrington, Joseph, Jacksonville	429, 493
Mentzer, Claude G., Miami	27	Farrior, J. Brown, Tampa	493, 697
Metzger, Frank C., Tampa	157	Fishbein, I. Leo, Miami Beach	496
Miles, Walter G., Chattahoochee	25	Grizzard, Vernon T., Jacksonville	366
Miller, Royston, Orlando	211	Hardy, Albert V., Jacksonville	497
Nathan, David A., Miami Beach	687	Herz, Ralph, Key West	637
Pearson, Homer L., Jr., Miami	215	Holland, Ned W., Tampa	562
Phillips, Kenneth, Miami	290	Hollender, A. R., Miami Beach	494
Pyle, Frank J., Orlando	475	Hotchkiss, Walter T., Miami Beach	431

(Continued on page 802)

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Commercial and
Publication
Printing

Isberg, Emil M., Miami Beach	431, 496, 499, 697
Kelley, William H., Orlando	499
Kells, Paul, Miami	367
Kirsh, David, Miami	294, 295
Lamar, Carlos P., Miami	500
L'Engle, Camillus S., Jr., Jacksonville	500
Lyerly, James G., Jacksonville	366
McEwan, Duncan T., Orlando	159
Marion, Donald F., Miami	562
Martin, Paul H., Jacksonville	160
Mathers, Fred, Orlando	565
Meares, Edward F., Sarasota	227
Mentzer, Claude G., Miami	499
Metzger, Frank C., Tampa	492
Michaels, John P., Orlando	295, 493, 563, 698
Newcomb, Wendell J., Pensacola	368, 495
Orr, Louis M., II, Orlando	227, 496, 565
Oshlag, Julius A., Miami Beach	430
Pipes, Ralph L., Belle Glade	366
Quillian, Warren W., Coral Gables	367
Rickard, Elsmere R., Tampa	698
Rogers, H. Milton, St. Petersburg	159, 494, 564
Rowntree, Leonard G., Miami	636
Scott, Joseph W., Miami	697
Snyder, John W., Miami	431
Stage, John T., Jacksonville	637
Stannus, Donald G., Miami	492
Steward, W. Dean, Orlando	227
Stewart, Joseph S., Miami	227
Suter, Max, Jacksonville	492
Toomey, John A., Cleveland, Ohio	638
Trupp, Mason, Tampa	563
Turner, A. Fred, Jr., Orlando	496
Unger, Paul N., Miami	295, 296, 368, 429
Williams, J. Maxwell, Jr., Tampa	565
Wilson, Wesley W., Tampa	227
Youmans, Iva C., Miami	228
Zellner, Robert E., Orlando	159
Zivitz, Nelson, Miami Beach	430

This June Journal

Contains

INDEX

From July 1949

Through June 1950

BOOKS RECEIVED

COAGULATION, THROMBOSIS, AND DICUMAROL, WITH AN APPENDIX ON RELATED LABORATORY PROCEDURES. By Shepard Shapiro, M.D., and Murray Weiner, B.S., M.S., M.D. Price, \$5.50. Pp. 131. New York: Brooklyn Medical Press, 1949.

Although not intended to be a complete review of coagulation, thrombosis and Dicumarol, this text nevertheless brings the reader abreast of the current theoretic and practical knowledge concerning thrombosis, hemorrhage and anticoagulant therapy. It is written primarily for the clinician and clinical pathologist, who face these problems repeatedly and cannot cope with the large and often contradictory literature about the subject.

Since anticoagulant therapy requires close cooperation between these two specialists and neither can afford to ignore the other's problems, the authors have treated the subject as a whole, rather than divide the text into clinical and laboratory sections. They present the history of Dicumarol as an excellent demonstration of the interdependence of pure and applied science and as a fascinating story of trials and tribulations, of periods of elation and depression such as accompany the achievements and disappointments of any research.

The senior author was one of the early pioneers in demonstrating the remarkable therapeutic effectiveness of Dicumarol, and his contributions to the technic of its proper use are well known. The text has, however, been organized with the view that the concepts developed will aid in the understanding not only of Dicumarol therapy but of anticoagulant therapy in general. An extensive appendix contains the quantitative clinical laboratory estimations related to thrombosis and hemorrhage.

THE FIRST ANESTHETIC, THE STORY OF CRAWFORD LONG. By Frank Kells Boland, M.D. Price, \$3.00. Pp. 160. Athens, Ga.: University of Georgia Press, 1950.

For many years Dr. Frank Kells Boland, Professor of Clinical Surgery, Emory University School of Medicine, and President, Crawford W. Long Memorial Association, has worked tirelessly to establish Dr. Crawford Long as the discoverer of surgical anesthesia. The century old controversy regarding this great discovery and the priority concerning its use has produced endless dispute and has focused more attention on the subject of anesthesia than on any other discovery in medicine. In the present volume Dr. Boland has uncovered new material yielding natural implications which produce evidence strong enough to convince the unprejudiced reader that Crawford Long is entitled to be acclaimed the true discoverer of this great boon to humanity.

This readable, well illustrated and interesting story adds a valuable chapter to the history of perhaps the greatest contribution to medicine.

COMMISSION ON CHRONIC ILLNESS, PROCEEDINGS OF FIRST MEETING, MAY 20, 1949. Price, 20 cents. Pp. 73. Commission on Chronic Illness, 535 North Dearborn Street, Chicago 10, Illinois.

The Proceedings of the initial conference of the Commission on Chronic Illness are now available in published form in response to the widespread interest in this meeting and in recognition of the distinctive contributions made by the technical advisers to the Commission.

Not a verbatim report, nor even a report of conclusions reached, the Proceedings are a body of expert opinion to be taken into account in launching and conducting the Commission's program. They include discussion of the problems facing everyone concerned with chronic illness. The opinions of the experts are of value not only to the Commission, but also to state and local communities currently engaged in planning or conducting studies, and in organizing new and improving established facilities.

THE COMMISSION ON CHRONIC ILLNESS. Free, on request. Pp. 19. Commission on Chronic Illness, 535 North Dearborn Street, Chicago 10, Illinois.

This informational booklet describes the origin, structure and objectives of the Commission on Chronic Illness. While members of the county medical societies may be acquainted with this organization and its proposed program, this brochure presents more complete information for educational or reference purposes.

Establishment of the Commission is the result of joint efforts of the American Hospital Association, American Medical Association, American Public Health Association, and American Public Welfare Association.

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Florida Medical Association	Herbert E. White, St. Augustine	Robert B. McIver, Jacksonville	Hollywood, Apr. 22-25, 1951
Florida Medical Districts	Russell B. Carson, Ft. Lauderdale	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Taylor W. Griffin, Quincy	Marianna
B-Northeast	Charles C. Grace, St. Augustine	Cleland D. Cochrane, Daytona Beach	Ocala
C-Southwest	H. Quillian Jones, Ft. Myers	M. Crego Smith, Clearwater	Ft. Myers
D-Southeast	Erasmus B. Hardee, Vero Beach	S. Marion Salley, Miami	West Palm Beach
Florida Specialty Societies			
Allergy Society	Clarence Bernstein, Orlando	Nelson Zivitz, Miami Beach	Hollywood, Apr. 22, '51
Anesthesiologists, Soc. of	Colquitt Pearson, Miami	Harold Carron, Tampa	" "
Chapter, Am. Acad. Gen. Prac.	T. D. Sandberg, Coral Gables	Vincent P. Corso, Miami	" "
Chapter, Am. Coll. Chest Phys.	Arnold S. Anderson, St. Petersburg	Alexander Libow, Miami Beach	" "
Derm. and Syph. Soc. of	J. Frank Wilson, Jacksonville	Wesley W. Wilson, Tampa	" "
Health Officers' Society	John M. McDonald, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Louie Limbaugh, Jacksonville	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Vernon A. Lockwood, St. Augustine	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Robert T. Spicer, Miami	Dorothy D. Brame, Orlando	" "
Ophthal. & Otol., Soc. of	R. Renfro Duke, Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Chas. L. Farrington, St. Petersburg	Herschel G. Cole, Tampa	" "
Pathological Society	Nelson A. Murray, Jacksonville	V. Marklin Johnson, W. Palm Beach	" "
Pediatric Association, State	Hugh A. Carithers, Jacksonville	Charlotte C. Maguire, Orlando	" "
Proctologic Society	Ralph F. Allen, Miami	Frederick E. Farrer, Miami	" "
Radiological Society	Floyd K. Hurt, Jacksonville	Thomas H. Lipscomb, Jacksonville	" "
Urological Society	Alvin L. Mills, St. Petersburg	George H. Putnam, Gainesville	" "
Florida—			
Basic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 3, '50
Dental Society, State	A. J. Fillastre, D.D.S., Lakeland	Larry Schulstad, D.D.S., Bradenton	
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	November, 1950
Hospital Service Corporation	Mr. W. E. Arnold, Jacksonville	Mr. H. A. Schroder, Jacksonville	November, 1950
Medical Examining Board	James L. Borland, Jacksonville	Frank D. Gray, Orlando	Jacksonville, June 25-27, '50
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 26, '50
Medical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 22, '51
Nurses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	Panama City, October, 1950
Pharmaceutical Association, State	Mr. E. E. Bludworth, Ft. Pierce	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Ruth Mettinger, R.N., Jacksonville	Mr. Fred B. Ragland, Jacksonville	St. Petersburg, 1950
Tuberculosis & Health Assn.	Mr. Dewey Knight, Miami	Mrs. Basil E. Kenney, Sr., Port St. Joe	Panama City, Mar. 30-31, '51
Woman's Auxiliary	Mrs. James L. Anderson, Miami	Mrs. C. R. Morgan, Jr., Miami	Hollywood, Apr. 23-25, '51
American Medical Association	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	San Francisco, June 26-30, '50
A. M. A. Clinical Session	Ernest E. Irons, Chicago	Geo. F. Lull, Chicago	Denver, Nov. 28-Dec. 1, '50
Southern Medical Association	Hamilton W. McKay, Charlotte, N. C.	Mr. C. P. Loran, Birmingham	St. Louis, Mo., Nov. 13-16, '50
Alabama Medical Association	J. M. Weldon, Mobile	Douglas L. Cannon, Montgomery	Mobile, Apr. 19-21, '51
Georgia, Medical Assn. of	Enoch Callaway, La Grange, Ga.	Edgar D. Shanks, Atlanta	Augusta, April 17-20, '51
S. E. Hospital Conference	Mr. James M. Crews, Memphis	Mr. L. H. Gunter, Montgomery	
Southeastern Allergy Assn.	Oscar H. Pruss, Durham, N. C.	Kath. B. MacInnis, Columbia, S. C.	St. Petersburg
Southeastern, Am. Urological Assn.	Edgar Burns, New Orleans, La.	Russell B. Carson, Ft. Lauderdale	Memphis, March 7-10, '51
Southeastern Surgical Congress	C. C. Howard, Glasgow, Ky.	B. T. Beasley, Atlanta	Hollywood, April 11-14, '51
Gulf Coast Clinical Society	G. O. Segrest, Mobile, Ala.	June McCafferty, Mobile, Ala.	Mobile, Ala.

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Franklin-Gulf	Donald H. Anderson, M.D. Wewahitchka	John W. Hendrix, M.D. Port St. Joe	Last Wednesday	6	100%	
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Leon-Gadsden- Liberty Wakulla- Jefferson	J. Lloyd Massey, M.D. 217 N. Madison St. Quincy	Edward C. Love, Jr., M.D. Box 385 Quincy	Quarterly 7:30 P.M.	4	44	
Suwannee	Irby H. Black, M.D. 918 W. Howard St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		7	100%	A-2-51 Taylor W. Griffin, M.D. Quincy
Madison	Eugene D. Thorpe, M.D. Madison	Julian M. DuRant, M.D. Madison		4	3	
Taylor *Dixie-Lojayette	George H. Warren, M.D. Perry	Walter J. Baker, M.D. Perry	Last Friday 8:00 P.M.	3	100%	

B

Alachua *Bradford, Gilchrist, Union	Stuart D. Scott, M.D. 331 W. University Ave. Gainesville	Henry H. Graham, M.D. 935 W. Arlington St. Gainesville	2nd Tuesday 8:00 P.M.	44	43	B-3-52 Eugene G. Peck, Jr., M.D. Ocala
Duval *Clay	James L. Borland, M.D. 430 W. Monroe St. Jacksonville	Samuel M. Day, Jr., M.D. 413 Professional Bldg. Jacksonville	1st Tuesday 8:15 P.M.	242	224	
Marion *Levy	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. 203 Professional Bldg. Ocala	3rd Tuesday 12:30 P.M.	28	100%	
Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	9	100%	
Putnam	Grover C. Collins, M.D. 502 Reid St. Palatka	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	2nd Tuesday 6:00 P.M.	10	100%	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
St. Johns	S. Raymond Cafaro, M.D. Exchange Bank Bldg. St. Augustine	Joseph A. Shelley, M.D. St. Augustine	3rd Tuesday 8:30 P.M.	14	13	
Brevard	Arthur C. Tedford, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	18	100%	
Lake *Sumter	Glendy G. Sadler, M.D. 315 N. Highland St. Mount Dora	Lawton F. Douglass, M.D. Eustis	1st Wednesday 7:30 P.M.	22	100%	
Orange *Osceola	Hollis C. Ingram, M.D. 303 Exchange Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	135	126	B-4-51 Cleveland D. Cochrane, M.D. Daytona Beach
Seminole	Charles L. Park, M.D. 109 W. 17th St. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	12	100%	
Volusia *Flagler	Eric H. Lenhoff, M.D. 101 Lenox Ave. Daytona Beach	Robert L. Miller, M.D. 258 1/2 S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	59	54	

C

Hillsborough	David R. Murphy, Jr., M.D. 442 W. Lafayette St. Tampa	Herschel G. Cole, M.D. 315 Wallace S. Bldg. Tampa	1st Tuesday 8:00 P.M.	154	145	C-5-51 M. Crego Smith, M.D. Clearwater
Manatee	Joseph A. Gibson, M.D. Palmetto	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	18	
Pasco-Hernando- Citrus	S. Carnes Harward, M.D. Box 313 Brooksville	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	12	11	
Pinellas	Albert R. Frederick, M.D. 403 Florida Power Bldg. St. Petersburg	Whitman C. McConnell, M.D. 313 First Federal Bldg. St. Petersburg	1st Monday 6:30 P.M.	172	169	
Sarasota	Talmadge S. Thompson, M.D. Box 224 Venice	Millard B. White, M.D. 151 S. Pineapple Ave. Sarasota	2nd Tuesday 8:30 P.M.	33	100%	C-6-52 Leldon W. Martin, M.D. Sebring
DeSoto-Hardee- Highlands- Glades	Roland W. Banks, M.D. Wauchula	James G. Smith, Jr., M.D. Wauchula	2nd Tuesday 8:00 P.M.	28	24	
Lee-Charlotte- Collier-Hendry	Walter B. Clement, M.D. Box 986 Punta Gorda	Roscoe S. Maxwell, M.D. Box 849 Punta Gorda	3rd Monday 7:30 P.M.	24	23	
Polk	Emmett E. Martin, M.D. 144 7th St. Haines City	John W. Vaughn, M.D. Box 475 Lakeland	2nd Wednesday 7:00 P.M.	83	74	

D

Indian River	Melton D. Council, M.D. Box 983 Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
Palm Beach	Charles McD. Harris, Jr., M.D. 1006 Comeau Bldg. West Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Dr. West Palm Beach	3rd Monday 8:00 P.M.	97	94	
St. Lucie- Okeechobee- Martin	Steve R. Johnston, M.D. Box 288 Ft. Pierce	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	15	14	
Broward	Richard A. Mills, M.D. 918 Las Olas Blvd. Ft. Lauderdale	Norris M. Beasley, M.D. 380 S. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	74	71	
Dade	Donald W. Smith, M.D. 310 Ingraham Bldg. Miami	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	535	436	D-8-51 S. Marion Salley, M.D. Miami
Monroe	Herman K. Moore, M.D. 600 Elizabeth St.	Wallace H. Mitchell, M.D. 217 Duval St.	2nd Thursday 8:00 P.M.			



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CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
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COPPER	0.5 mg.	CALORIES	676

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